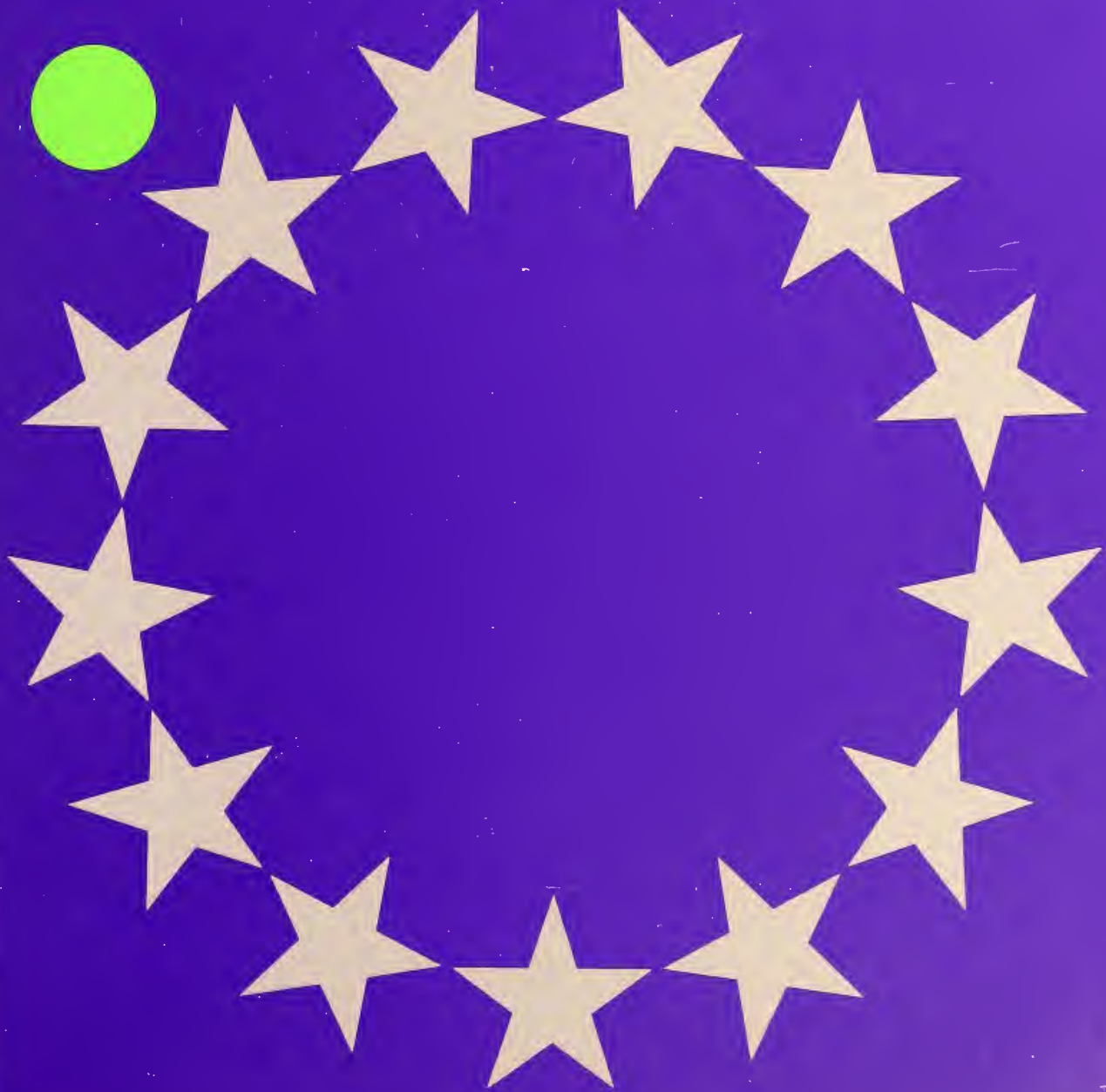
GAINING GROUND: STATE INITIATIVES FOR PREGNANT WOMEN AND CHILDREN

NATIONAL GOVERNORS' ASSOCIATION

State Policy Reports

Health Policy Studies

Conference Proceedings May 1-3, 1991 San Francisco, California



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Edited by Janine M. Breyel

Health Policy Studies
Center for Policy Research

National Governors' Association

The National Governors' Association, founded in 1908 as the National Governors' Conference, is the instrument through which the nation's Governors collectively influence the development and implementation of national policy and apply creative leadership to state issues. The association's members are the Governors of the fifty states, the commonwealths of the Northern Mariana Islands and Puerto Rico, and the territories of American Samoa, Guam, and the Virgin Islands. The association has seven standing committees on major issues: Agriculture and Rural Development; Economic Development and Technological Innovation; Energy and Environment; Human Resources; International Trade and Foreign Relations; Justice and Public Safety; and Transportation, Commerce, and Communications. Subcommittees and task forces that focus on principal concerns of the Governors operate within this framework.

The association works closely with the administration and Congress on state-federal policy issues through its offices in the Hall of the States in Washington, D.C. The association serves as a vehicle for sharing knowledge of innovative programs among the states and provides technical assistance and consultant services to Governors on a wide range of management and policy issues.

The Center for Policy Research is the research and development arm of NGA. The center is a vehicle for sharing knowledge about innovative state activities, exploring the impact of federal initiatives on state government, and providing technical assistance to states. The center works in a number of policy fields, including agriculture and rural development, economic development, education, energy and environment, health, information management, social services, trade, training and employment, and transportation.

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Contents

Foreword

In May 1991 the National Governors' Association convened a national conference to assess the progress states are making to improve the health status of mothers and children. "Gaining Ground: State Initiatives for Pregnant Women and Children," held May 1-3, 1991, in San Francisco, California, provided attendees with an opportunity to evaluate the impact of prenatal care reforms, explore approaches for improving children's health, and learn about strategies for meeting the special needs of pregnant women who abuse alcohol and other drugs and of the infants exposed prenatally to these substances. Conference participants shared information on innovative policies and programs and exchanged ideas on the work that still remains to address the critical problems facing the nation's mothers and children.

Since the passage of the Omnibus Budget Reconciliation Act of 1986, which first allowed states to sever the historical link between Medicaid and Aid to Families with Dependent Children in order to raise income eligibility thresholds for pregnant women and young children, significant reforms to public programs serving these populations have been made. Upon the two-year anniversary of the initial effective date of this legislation, the National Governors' Association (NGA) brought together state and federal health officials involved in the nation's fight against infant mortality. At this meeting, held March 29-31, 1989, in San Antonio, Texas, it was apparent that Medicaid and Maternal and Child Health agencies were collaboratively designing and implementing creative programs to serve mothers and children.

Yet, two years later, questions still remained and other issues had emerged. NGA believed that it would be valuable to once again convene the key players to discuss the progress to date and to share ideas on how to address the new issues. More than 250 individuals representing state and federal agencies, including Maternal and Child Health, Medicaid, Alcohol and Drug Abuse, WIC, and Community and Migrant Health Centers, as well as consumer and provider associations, universities, and advocacy groups gathered in San Francisco to accomplish these important objectives.

Both national meetings were convened as part of NGA's ongoing project, "Facilitating Improvement of State Programs for Pregnant Women and Children." Supported since 1987 by a cooperative agreement with the Maternal and Child Health Bureau in the Health Resources and Services Administration of the U.S. Public Health Service, NGA has been closely monitoring and analyzing states' efforts to design and implement effective programs for pregnant women and children. Under the project a series of reports have been developed that highlight and discuss state initiatives to broaden financial access, streamline eligibility systems, increase awareness of the importance and availability of care through outreach and public education campaigns, recruit and retain obstetrical and pediatric providers, and develop comprehensive health programs for these critical populations.

Recent state efforts were presented at the conference, "Gaining Ground: State Initiatives for Pregnant Women and Children." Participants were given a unique opportunity to examine prenatal care reforms to determine whether states have successfully enrolled eligible pregnant women in the Medicaid program, to explore how states

can better measure access and track shifts in provider participation, and to assess whether state prenatal care enhancements have resulted in better birth outcomes. Attendees explored how the lessons learned in the implementation of successful perinatal programs can be applied to the design of effective health programs for children. Discussions focused on how states can enhance children's access to pediatric providers; ensure that all children receive routine, preventive health examinations; and effectively provide treatment services to those children with complex and chronic health needs. Participants also analyzed the growing challenge of caring for pregnant women who abuse alcohol and other drugs and for the infants exposed prenatally to these substances. The nature and extent of this problem was explored, the unique treatment needs of these women and infants were identified, and collaborative programs and policies were highlighted.

These proceedings capture the experiences and insights of conference participants by summarizing the presentations of researchers and state and federal health officials. The report is organized into three broad sections: "Evaluating the Impact of Perinatal Care Reforms," "Improving Children's Health Care Programs," and "Responding to the Needs of Substance-Abusing Pregnant Women and Their Infants."

The National Governors' Association wants to congratulate all of the conference attendees for their engaging and active participation in this important meeting. This publication will make it possible for those persons not in attendance to learn from the exciting dialogue that took place in San Francisco.

Acknowledgements

The National Governors' Association (NGA) acknowledges the generous financial assistance provided by the U.S. Public Health Service to support its highly successful conference, "Gaining Ground: State Initiatives for Pregnant Women and Children."

This conference proceedings is the ninth report in a series developed under the project, "Facilitating Improvement of State Programs for Pregnant Women and Children." Supported through a cooperative agreement with the Maternal and Child Health Bureau (MCHB), Health Resources and Services Administration, Public Health Service, U.S. Department of Health and Human Services, this project serves to highlight and share information regarding innovative, collaborative state efforts to implement more accessible and effective perinatal and child health programs. For her assistance in framing both the research agenda of the project and many of the issues addressed at the conference, sincere appreciation is extended to Ann Koontz, MCHB project officer. For his help in project development, gratitude also is extended to David Heppel at MCHB.

This publication represents the collaborative efforts of a number of people. NGA is especially grateful to conference participants for their substantial contributions during the meeting and for their valuable comments on early drafts of the proceedings. The assistance of Ian Hill, who was the former project director of "Facilitating Improvement of State Programs for Pregnant Women and Children" and who was instrumental in the development of the conference, also is greatly appreciated. Mr. Hill's critical insights and invaluable guidance have ensured the success of the project since its inception in 1987.

This publication was edited by Janine Breyel, senior research assistant at NGA, based on transcripts of the speakers' presentations. Kathleen Miller, who assisted Ms. Breyel with this activity, deserves special mention. Thanks also are extended to John Luehrs for his ongoing helpful guidance, to Barbara Tymann and Stephanie Cook-Hall for their skillful preparation of the manuscript, and to Karen Glass for her careful and professional editorial assistance.

"As the principal agency within the U.S. Department of Health and Human Services charged with filling the gaps in health care for the poor and disadvantaged populations, a high priority of the Health Resources and Services Administration (HRSA) is to create stronger federal, state, and local public/private partnerships. It's important that we work in close collaboration with state and local governments, nonprofit organizations, academia, private practitioners, and advocacy groups.

"In that spirit, HRSA and the Health Care Financing Administration (HCFA) have begun working together to develop strategies for ensuring access for the vulnerable populations we share. We have two major types of activity. One is targeted toward increasing the number of pregnant women and infants receiving services. The second is aimed at ensuring adequate capacity to provide care to these populations. Collaborative efforts take many forms. For example, HCFA is involved in helping to develop the selection criteria, location, and care content of HRSA service delivery programs. Conversely, HRSA contributes to HCFA program guidance and regulations. We encourage our counterparts at the state and local levels to also work in tandem. Through shared resources and cooperation, we believe that we can successfully improve the health status of women and children across the country."

Robert Harmon, M.D.
Administrator
Health Resources and Services Administration

"Be it at the federal, state, or local level, there are many things that Medicaid and our Maternal and Child Health counterparts share in common. First, and most important, we share a common commitment to the goal of ensuring healthy births, reducing low birthweights, and improving the health status our children. Second, we all recognize the importance of supporting the creativity and uniqueness of local planning efforts. And we support the efforts of states and local communities in developing programs that best meet and support this need. We each have a unique role in achieving our goals in this area. Medicaid provides the financing to help deliver services. The Maternal and Child Health Bureau has the program expertise, the capacity-building dollars, and public information experience needed to respond locally to the needs of our common populations. I think a lot of ground has been gained across the country in a variety of areas. New programs, renewed commitments, and innovative ideas have resulted in changes and we are making progress.

Christine Nye
Director
Medicaid Bureau
Health Care Financing Administration

Executive Summary

Policymakers at all levels of government are beginning to ask whether states' efforts to improve the health status of pregnant women and children are working. At a recent National Governors' Association conference, state and federal health officials convened to assess what progress has been made as a result of reforms for pregnant women. In addition, ideas were shared on how the lessons learned from developing programs for pregnant women could be applied to improving child health programs. Strategies for addressing emerging issues such as substance abuse during pregnancy also were discussed.

Translating Eligibility Expansions into Enrollment

In many states broadened Medicaid coverage, streamlined eligibility processes, and targeted outreach were implemented more than four years ago. Have these initiatives been successful in enrolling women made eligible through Medicaid expansions? Results from both national and state studies are showing that states are experiencing increased numbers of women enrolled in their programs. States such as Maryland and Vermont have seen steady increases in the number of births paid for by the state since they implemented reforms to their Medicaid programs. Yet, financial eligibility is only a part of the access equation.

Measuring Access and Tracking Shifts in Provider Participation

Women's access to health care depends on many factors, including geography, transportation, hours of operation, and perhaps most important, provider participation. But studies of provider participation are proving that simple counts of private physicians with a Medicaid billing number produce data that are of limited use to policymakers. Evaluations of the availability of prenatal care services also must take into account systems of care such as clinics, participating physicians' level of effort, and the unique needs of individual communities.

Assessing the Results of Prenatal Care Reforms

Evaluations of perinatal programs can provide policymakers with valuable feedback on the key elements of an effective program. However, it is extremely important that evaluations are planned up front, and that evaluators are involved in planning and implementation in order to ensure that appropriate program variables and interventions are studied. Although it is too early to see significant changes in infant mortality rates, initial results from program evaluations are promising. These studies have produced some exciting information, including higher enrollment rates than estimated, correlations between improved birth outcomes and new programs, and decreased costs associated with new initiatives. More data are needed, however, to ensure wise investment of public resources.

Designing a Model Child Health System

States are struggling to develop comprehensive programs to ensure that all children grow up physically, mentally, and socially healthy. By applying the lessons learned during the development and implementation of successful initiatives for pregnant women, states are creating programs that incorporate multiple interventions to address multiple needs; take into account the specific needs, resources, and service gaps in specific communities; and include broad outreach services.

Improving Children's Access to Care

Most states are aggressively pursuing initiatives to ensure that pediatric provider participation levels do not become critically low—a situation that has occurred with obstetrical providers. Many also are seizing this opportunity to implement creative fee schedules that tie quality assurances to increased reimbursement. Michigan and New York have recently implemented new provider programs that are intended not only to improve participation, but also to improve the quality of care provided to children. Efforts such as these are expected to improve children's access to effective preventive care.

Ensuring That All Children Receive Preventive Care

The flexibility allowed states in the management of the Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program can facilitate their efforts to improve children's health. Several states have developed innovative approaches for reaching out to eligible children, informing them of EPSDT benefits, encouraging their participation, and helping guide them through the program. Models such as those developed in California, which uses local health departments to manage children's care; in South Carolina, which employs public health nurses to make home visits to families with eligible children; and in Pennsylvania, which contracts with a private firm to carry out all phases of the program, have all proven successful in ensuring that eligible children receive regular preventive screening examinations.

Linking Treatment Services to Screening Services

Much like what has been done successfully for pregnant women, states are beginning to think about how multiple state agencies can collaborate to develop a system that will successfully enroll, screen, and treat eligible children. Florida and New Mexico are two states that have built a comprehensive treatment program for children based on interagency coordination. Both include a strong care coordination component to ensure linkages between screening examinations and needed diagnostic and treatment services.

Understanding the Nature and Extent of Perinatal Substance Abuse

Specific initiatives are required to reach and treat pregnant women who are substance abusers and their exposed infants. Recent studies are revealing that education is needed to recognize the signs of addiction and abuse, especially for health care providers serving pregnant women. New information on the effects of substance abuse on fetal

development indicates that treatment at any time can have a positive impact. Policymakers are turning their attention to removing the barriers that many pregnant women face in accessing treatment for substance abuse.

Responding to the Maternal Substance Abuse Problem

Policymakers at all levels of government have identified substance-abusing pregnant women as a priority. At the federal level, the expertise and resources of many agencies are being coordinated to plan and fund joint demonstration and research projects targeted to pregnant substance abusers. Also important is the development of mechanisms for sharing information on successful strategies.

Financing Substance Abuse Treatment Services

In their efforts to fund substance abuse treatment programs for pregnant women, many states are turning toward Medicaid because of its historical role in reimbursing for health services provided to low-income populations. Among the different Medicaid service categories, many options exist to fund treatment services. Given states' difficulty in raising new revenue for substance abuse treatment services, Medicaid may be the only vehicle for paying for these services.

Developing State Programs to Serve Substance-Abusing Pregnant Women

By pooling the resources of multiple agencies, states are developing programs that incorporate both specialized alcohol and drug abuse treatment services and important health care services. California, Oregon, and Washington have implemented innovative policies and programs that involve the resources and expertise of Alcohol and Drug Abuse, Maternal and Child Health, Medicaid, and Child Welfare agencies, and that are aimed at meeting the complex needs of pregnant women who abuse alcohol and other drugs.

I. Evaluating the Impact of Perinatal Reforms

"In this era of limited resources, increased emphasis has been placed on assessing the effects of our efforts. A crucial role of the Maternal and Child Health Bureau is to make certain that the knowledge and wisdom gained at the implementation level is broadly communicated."

Ann Koontz
Chief
Maternal and Infant Health Branch
Maternal and Child Health Bureau
Health Resources and Services Administration

"We are very much on the line to deliver results. Congress and other decisionmakers have expectations and are eager to see the results of the mandates, expansions, and program changes. People are looking for outcomes. It is important for us to communicate those things that we have already achieved more effectively."

Christine Nye
Director
Medicaid Bureau
Health Care Financing Administration

1. Translating Eligibility Expansions into Enrollment

Since 1986, all states have dramatically expanded Medicaid eligibility thresholds for pregnant women and infants. All states now cover pregnant women and children with incomes up to 133 percent of the federal poverty level. Additionally, thirty-one states have elected to go beyond 133 percent of poverty, with twenty-four states at the highest level permitted—185 percent (see Table 1). Several states have expanded coverage for pregnant women beyond Medicaid through state-funded programs. For example, California, Massachusetts, and Vermont cover pregnant women with incomes up to 200 percent of the federal poverty level, using state funds to cover those above Medicaid eligibility thresholds.

As important as higher income eligibility thresholds are to ensuring financial access, other barriers may prevent pregnant women from obtaining needed care. Women may not know about available benefits or not realize the importance of prenatal care. Many eligible women may be uncomfortable with the Medicaid enrollment process. Historically, the Medicaid eligibility process, due to its link to welfare, has been notorious for its complexity. Cumbersome application forms, lengthy processing delays, and inconveniently located application sites prevented many eligible women from accessing the program.

Recognizing this problem, many states have streamlined Medicaid eligibility processes to make it easier for pregnant women to become eligible for the program. The Omnibus Budget Reconciliation Act of 1986 (OBRA-86) allowed states to drop the assets test when determining Medicaid eligibility for pregnant women, greatly reducing the amount of verification required when applying for the program. The legislation also allowed states to grant presumptive eligibility so that these women could be given immediate, temporary coverage. Continuous eligibility for pregnant women throughout pregnancy and the sixty-day postpartum period, regardless of fluctuations in income—previously an option allowed under OBRA-86—was mandated by the Omnibus Budget Reconciliation Act of 1990 (OBRA-90). In addition, states have made other reforms to the Medicaid eligibility process, including simplifying and shortening Medicaid application forms, reducing the determination processing period, outstationing eligibility workers at sites where pregnant women receive care, and eliminating the requirement for face-to-face interviews when applying for Medicaid.

In conjunction with these eligibility streamlining efforts, many states also began a number of outreach efforts to inform potentially eligible women of the availability of benefits and of the importance of prenatal care. These have included the installation of toll-free hotlines; the development of brochures, posters, and public transportation placards; and the design of multimedia public information campaigns.

Table 1
States With Expanded Eligibility for Pregnant Women and Infants

State	*Current Percentage of Poverty*	*Effective Date of Original Expansion**
Alabama		July 1988
Alaska		January 1989
Arizona	140%	January 1988
Arkansas	185%	April 1987
California	185%	July 1989
Colorado		July 1989
Connecticut	185%	April 1988
Delaware	160%	January 1988
District of Columbia	185%	April 1987
Florida	150%	October 1987
Georgia		January 1989
Hawaii	185%	January 1989
Idaho		January 1989
Illinois		July 1988
Indiana	150%	July 1988
Iowa	185%	January 1989
Kansas	150%	July 1988
Kentucky	185%	October 1987
Louisiana		January 1989
Maine	185%	October 1988
Maryland	185%	July 1987
Massachusetts	185%	July 1987
Michigan	185%	January 1988
Minnesota	185%	July 1988
Mississippi	185%	October 1987
Missouri		January 1988
Montana		July 1989
Nebraska		July 1988
Nevada		July 1989
New Hampshire		July 1989
New Jersey	185%	July 1987
New Mexico	185%	January 1988
New York	185%	January 1990
North Carolina	185%	October 1987
North Dakota		July 1989
Ohio		January 1989
Oklahoma	185%	January 1988
Oregon		November 1987
Pennsylvania		April 1988
Rhode Island	185%	April 1987
South Carolina	185%	October 1987
South Dakota		July 1988
Tennessee	185%	July 1987
Texas	185%	September 1988
Utah		January 1989
Vermont	185%	October 1987
Virginia		July 1988
Washington	185%	July 1987
West Virginia	150%	July 1987
Wisconsin	155%	April 1988
Wyoming		October 1988
Total	31	

NOTE: * Reflects the date the state first adopted optional authority to expand the Medicaid eligibility threshold for these populations.

SOURCE: National Governors' Association, *MCH Update*, January 1992.

Many of these outreach efforts and reforms to states' eligibility systems were implemented more than four years ago. Have states been successful in reaching pregnant women and enrolling them into Medicaid? Are more women receiving prenatal care as a result of these efforts? States are now beginning to evaluate these processes to determine whether they are having the desired effects, and as will be described in subsequent chapters, the answers to these questions are beginning to emerge.

The General Accounting Office's Study on Enrollment

In May 1989 Congress asked the General Accounting Office (GAO) to evaluate states' successes in enrolling into Medicaid the pregnant women made eligible by recent expansions. GAO selected for study ten states that had adopted optional Medicaid expansions by January 1988 (Arkansas, Florida, Kentucky, Maryland, Mississippi, New Jersey, New Mexico, Oregon, Washington, and West Virginia). Variations in program design, expansion patterns, geography, and demographics all played a part in the selection process. GAO also was asked to study and characterize the types of outreach activities initiated by these states.

GAO staff interviewed Medicaid, Maternal and Child Health, and other public health officials in the ten states. Both Medicaid eligibility data and hospital discharge data were reviewed. In addition, GAO staff researched vital statistic data to identify demographic trends of pregnant women that could have had an impact on the expansions. Through these efforts, GAO was able to complete a descriptive analysis of the states' eligibility expansion processes.

The GAO study concluded that all of the study states had made significant reforms to their Medicaid eligibility process, and as a result, two-thirds to three-fourths of those estimated to be eligible based upon Census data were enrolled in Medicaid within two years following enactment of the expansions. State strategies included those documented in NGA research such as the dropping of the assets test, the adoption of continuous eligibility, and the outstationing of eligibility workers. GAO found that referral efforts between local health organizations and Medicaid were enhanced. Outreach such as case finding, toll-free hotlines, and mailings to potentially eligible women also were a part of the ten study states' efforts. GAO found that the dropping of the assets test and the implementation of presumptive eligibility were most closely associated with increased enrollment.

GAO also examined Medicaid claims data in Florida and Oregon to determine whether the eligibility expansions resulted in a statistically significant increase in deliveries paid for by Medicaid. By looking at Medicaid-financed deliveries for the months before and after the expansions and by using an interrupted time series analysis, GAO concluded that the growth was significant. In Florida the number of deliveries paid for by Medicaid rose from about 19 percent of all births in the state to about 27 percent. Prior to the expansion the Medicaid program in Oregon was paying for about 15 percent of all deliveries in the state; after the expansion this figure rose to 26 percent. To ensure that other factors did not cause this growth, vital records were examined. There was essentially no change in the proportion of women in high-risk demographic

categories, indicating that there were no major shifts in the overall population that could have contributed to these increases in Medicaid-financed deliveries.

The GAO evaluation found that states have made impressive reforms to their Medicaid eligibility systems. Eligibility expansions, streamlining strategies, and outreach efforts have all contributed to the success states have had in enrolling eligible pregnant women. In addition to GAO's national study, many states have conducted their own analyses of new programs. Two states that have conducted their own studies to evaluate newly implemented perinatal programs are Maryland and Vermont. Their programs are described below.

Maryland's Outreach Efforts and Presumptive Eligibility Program

To address alarmingly high rates of infant mortality and morbidity, Maryland made changes to its Medicaid program to improve the accessibility of health care for pregnant women beginning in 1987. The first change helped remove financial barriers to care by raising the Medicaid eligibility threshold to 100 percent of poverty in 1987 and then further to 185 percent of poverty in 1989. The second strategy focused on removing the bureaucratic barriers that prevented many pregnant women from obtaining Medicaid eligibility. Components of this strategy included dropping the assets test, adopting continuous eligibility, and implementing presumptive eligibility in all of the state's health departments and community health centers. Efforts also were made to ensure that women served at these sites were linked to both prenatal care and the Special Supplemental Food Program for Women, Children, and Infants (WIC). In 1990 the state also added presumptive eligibility in hospital outpatient departments because it was found that many women were receiving primary health care services at these sites.

Maryland also has implemented enhancements to its perinatal benefit package to ensure that women receive necessary services. Case management, health education, nutritional counseling, psychosocial counseling, home visits, and outpatient drug treatment are all now covered under Medicaid. The state also wanted to ensure that a sufficient number of providers would be available to serve the expanded group of newly eligible women. Fee increases were implemented, and public health nurses were hired to do one-on-one physician recruitment.

Once the new system was fully operational, Maryland began an aggressive public information campaign that included a toll-free hotline, radio and television announcements, posters, and billboards. Various aspects of the media campaign are coordinated with the state Blue Cross/Blue Shield Association, which finances television advertisements and provides support for much of the printed materials.

Program data demonstrate that the state has done an effective job in reaching out to pregnant women. For example, as the GAO study concluded, Maryland has succeeded in enrolling nearly 100 percent of the low-income pregnant women estimated to be eligible for Medicaid. In addition, the number of deliveries paid for by Medicaid has increased by 42 percent since the eligibility expansions were first implemented.

Vermont's Co-enrollment Strategy

Vermont also aggressively expanded Medicaid eligibility for pregnant women when given the option and is currently covering this population at the maximum level allowed—185 percent of poverty. Having implemented the expansion, the Department of Social Welfare, which administers the Medicaid program, wanted to develop a comprehensive strategy to attract and enroll the newly eligible women into the program. Recognizing the need for nutritional services as well as health care during pregnancy, the Department of Social Welfare collaborated with the Department of Health, which administers WIC, to develop a unified approach to increase enrollment in these two critical programs.

The Departments of Health and Social Welfare first identified barriers hampering enrollment in both programs, such as long processing delays, cumbersome application forms, and a lack of knowledge of available services. Together the agencies formulated a three-pronged strategy to address these problems.

- **Development of a joint application form.** After reviewing the eligibility requirements for both Medicaid and WIC, the state discovered that with a few policy changes, such as dropping the assets tests and excluding parental income for teenagers, a single, one-page application form for both programs could be developed. The application can be taken at either a WIC site or a district health and welfare office (the traditional Medicaid application site).
- **Development of a protocol to ensure that eligibility determinations are made within ten days.** To ensure that pregnant women are granted eligibility quickly, the two agencies developed a protocol that requires new applications to be forwarded to the other department within one working day.
- **Implementation of a mass media outreach campaign.** The Help Your Baby, Help Yourself campaign emphasized the importance of prenatal care, with a particular focus on pregnant teenagers. The messages reflect the fear teenagers feel when discovering they are pregnant. Campaign materials include television and radio public service announcements, posters, brochures mailed with utility bills, and a toll-free hotline.

The program has been very successful. The joint application is available at sixty-three WIC sites and twelve district health and welfare offices across the state—greatly increasing the number of locations where women can apply for benefits. The media campaign has shifted its focus to children and been renamed the Dr. Dynasaur program. The new name is expected to be more welcoming and attractive to children and their parents and to increase awareness of the availability and importance of preventive health care.

Although the percentage of births covered by Medicaid was slowly decreasing during the mid-1980s, the advent of the new expansions in Medicaid resulted in a rise in this figure. In 1988 the state paid for 1,245 births through Medicaid, in 1990 1,420 births were covered by Medicaid, and in 1991 1,704 births were Medicaid-financed. State officials believe that this steady increase is a clear indicator of the success of their efforts.

Conclusion

Clearly, Medicaid eligibility expansions have served as a catalyst for states to implement other strategies to enroll more pregnant women into the program. However, while the data indicate that expansion efforts have been successful, questions remain. For example, the GAO study showed that states have increased the number of pregnant women enrolled in Medicaid but it did not carefully assess which interventions were the most effective in getting women into the program. Moreover, a Medicaid card alone does not ensure that women have access to the prenatal care needed for healthy births. State-initiated expansions and enrollment strategies that have been successful in reaching pregnant women represent only the first step in addressing the complex problem of infant mortality.

2. Measuring Access and Tracking Shifts in Provider Participation

Although states have made impressive progress in ensuring that more pregnant women have financial access to health care through Medicaid expansions, challenges remain in ensuring that prenatal care services are received. One serious problem states continue to struggle with is ensuring that there are enough obstetrical providers willing to care for the growing number of Medicaid-eligible pregnant women. Inadequate provider participation in Medicaid has been an ongoing concern to states and the federal government for many years. Congress sought to address this problem through two provisions in the Omnibus Budget Reconciliation Act of 1989 (OBRA-89).

One provision of this legislation requested the Physician Payment Review Commission (PPRC) to examine Medicaid physician rates. This congressional commission, which was established to study the adequacy of Medicare physician rates, was instructed to place Medicaid physician rates under the same scrutiny. Working with the National Governors' Association, PPRC conducted a national survey to gather information on physician fees and participation, and the impact that these factors have on access to care in the Medicaid program. Survey results indicated that forty-four states are experiencing problems with physician participation in their Medicaid programs. Ninety-three percent of those states reported participation problems among obstetricians/gynecologists, and about 25 percent of those states shared concerns regarding pediatric participation.

The study further confirmed that Medicaid physician payment rates were lower than those for Medicare. It is argued that a low payment rate is one factor that limits provider participation, though by no means is it the only factor. High malpractice premiums, fear of lawsuits, and complex administrative billing procedures all contribute to low levels of provider participation.

Another provision of OBRA-89 that sought to address the critical problem of provider participation requires states to demonstrate to the Secretary of Health and Human Services that obstetrical and pediatric services are available to Medicaid recipients at least to the extent that such services are available to the general population. This "equal access" provision was keyed to state payments, and requires states to annually submit Medicaid reimbursement rates for obstetrical and pediatric services to the Health Care Financing Administration (HCFA) beginning April 1, 1990. States also are asked to submit any additional data that can verify compliance with at least one of three standards:

- At least 50 percent participation by obstetricians and pediatricians on an appropriate substate geographic basis (or the same rate as Blue Cross/Blue Shield participation); or

- Fee-for-service payment rates for all obstetrical and pediatric services that are at least 90 percent of the average payment by private insurers in the state; or
- Other appropriate means documented by the state to demonstrate equal access.

Unfortunately, most analysts agree that adherence to the HCFA standards does not provide sufficient evidence that recipients have access to care. Furthermore, even if that were the case, most states cannot provide the data that are required by these standards. Because systems are not equipped to provide the information that is needed to accurately answer questions of physician participation and how participation affects access to care, states continue to struggle with these problems.

Identifying Problems with Provider Participation Data

States need to know how many physicians are participating in their Medicaid programs for several reasons. The most obvious reason is to document the extent to which physicians serve Medicaid recipients and to identify gaps where services are not available. Yet, increased provider participation is not an end in itself. It is desired only insofar as it improves availability, and ultimately, access to care. The important question is not, "do physicians participate?", but rather, "does the Medicaid delivery system, of which physicians are an important part, have sufficient capacity to serve Medicaid recipients?"

The ability of state programs to effectively monitor changes in physician participation—and the effect of these changes on the availability of care—has been limited. Long-standing data problems inherent in the structure of Medicaid management information systems have frustrated states' ability to accurately document the number of participating physicians and the extent of their participation. The need to improve monitoring capabilities received new importance when Congress enacted the "equal access" provision in OBRA-89.

Most of the data currently available concentrate on identifying the number and distribution of physicians participating in Medicaid by specialty and area within the state. When conducting these studies the same assumption is used: Higher fees lead to greater participation, which leads to increased access. More and more, this assumption is being challenged because it ignores two major issues: the number of patients the participating doctors serve and the role of the clinic system, such as local health departments and community health centers, in providing care.

Defining Provider Participation

Mainly due to data limitations, Medicaid agencies have commonly used a dichotomous definition of provider participation—does the physician have a Medicaid provider number and did he or she serve at least one Medicaid beneficiary during a given period of time? Use of this definition makes an implicit assumption that increasing the number of physicians who participate in Medicaid will increase access to care. While this may be true, it may not be sufficient. Changes in caseload or the level of effort among participating physicians may have a greater impact on access.

A level of effort definition, in which only physicians providing care to a predetermined number of Medicaid beneficiaries during a given period of time are counted as participating, may give a more complete measurement. The level of effort definition attempts to exclude those physicians who serve only an occasional Medicaid recipient. While such a definition is used frequently by researchers and evaluators, this level of effort definition rarely is used by Medicaid agencies because they do not have easy access to more sophisticated data.

Exploring the Role of the Clinic System

While considerable attention has been focused on physicians over the years, much less attention has been paid to the role of the clinic system when attempting to measure access to care. This is ironic given the fact that providers such as health department clinics, health maintenance organizations, and community health centers often deliver comprehensive prenatal care services. Many reasons exist for this lack of attention including billing patterns of clinics that make it difficult to track services provided to Medicaid recipients. Yet, it is difficult to determine whether low physician participation alone generates problems in the availability of care without taking into account the role of clinics.

Measuring the Availability of Care

Many problems will continue to hamper states' ability to identify participating providers. These include inaccurate licensure files, out-of-date information on the status of a physician's practice, and a lack of physician specialty data. However, if states want to obtain a more accurate picture of access within their boundaries and not simply a count of physicians with Medicaid billing numbers, several approaches might be considered.

- **Define the level of effort**. With this approach, a state would select a service (e.g., well-child visit) by reviewing Medicaid claims data and identify the pool of physicians who provide this service.

  By aggregating the total services rendered, information on the distribution of physicians by the number of services rendered can be obtained. Similarly, this approach can be used to obtain information on the number of beneficiaries served by each physician by aggregating the total number of Medicaid beneficiaries.

- **Estimate the capacity and need.** This approach would include the clinic system in the access equation. To measure how well the state is meeting the need for services, an estimate of the capacity of the entire Medicaid delivery system is made and compared with the needs of the eligible population.

- **Develop an early warning system**. Rather than providing a measurement of access, this approach would highlight when potential access problems may occur. Information is obtained by building a baseline of data on the number of services rendered in the past in a particular county or other geographic area in the state. Changes in the provision of these services are periodically

tracked. Potential problems are flagged by any significant changes in the provision of these services.

Each approach can provide useful information to states. However, each has both advantages and disadvantages. By defining a level of effort, the state can measure the availability of physicians and obtain information on those serving a large number of Medicaid clients. This measurement also can be used to identify the distribution of providers across the state and the types of care they render. One disadvantage of this approach is the difficulty in accessing the data needed to formulate this methodology. Beyond this, however, a serious policy issue arises: Level of effort data will yield a lower number of physicians who provide services to Medicaid beneficiaries. The assurances to HCFA now required by OBRA-89 thus will be more difficult to provide.

These issues may be addressed if the clinic system is included when measuring access. A major disadvantage of this approach, however, is that the data are very difficult to acquire. To estimate system capacity, the number of patients who can be served by local health departments, community health centers, and other entities is needed, in addition to the number of people on Medicaid and information on their health needs. Collecting these data requires addressing major data problems. In the long term, however, this measurement may prove more useful than simply looking at the private physician delivery system.

The major disadvantage of the early warning approach is that it does not truly measure access. However, the ability to identify areas where potential access problems may develop can be useful to states. Additionally, because all the information needed can be found in Medicaid claims files, this approach is relatively simple to implement.

These three approaches can help states measure the availability of services for their Medicaid clients. They also provide the tools to help refocus the discussion. For too long, policymakers have established provider participation rather than access as the goal. One state that has moved beyond the participation question to really examine the degree of access in its perinatal program is Washington. This state's experience is described below.

Assessing Access in Washington's First Steps Program

Implemented in August 1989, the First Steps program in Washington is designed to improve access to health care for low-income pregnant women. To reduce financial barriers to care, Medicaid eligibility was expanded to 185 percent of poverty. To meet the needs of low-income pregnant women beyond medical care, an enhanced perinatal care package was adopted that includes support services and case management. To ensure the availability of providers willing to serve this population, obstetrical fee increases were instituted.

The legislation establishing the program also required that an evaluation of the program be completed. The legislature asked the University of Washington to focus on eight specific objectives in the evaluation, one of which is to measure the impact of the fee increases on physician participation. Recipient characteristics, utilization of services, impacts on access to care, costs of care, health outcomes, and gaps in services are other issues the legislature asked the evaluators to examine.

The evaluation will be conducted over the first four years of the program. Although the program is still relatively new, important data already have been collected, especially on physician participation. Several data collection methods have been used, including surveys of obstetrical providers, site visits, and the linkage of several key data sets. These linkages have proven critical because of the information they are providing. Specifically, the University of Washington has worked with the Department of Social and Health Services to link eligibility, provider, and claims data from the Medicaid management information system, vital statistics database, and Comprehensive Hospital Discharge Abstract System, which is an all-payor hospital discharge database.

These data sets have allowed the evaluators to measure physician participation in three ways: the percentage of physicians participating in Medicaid, the number of deliveries each physician performs to low-income women, and the proportion of each physician's practice that is devoted to caring for low-income women.

To determine the percentage of physicians participating in Medicaid, the evaluators collected information on all births. They discovered that in 1989 about 36 percent of the approximate 67,000 babies delivered in the state were born to low-income women. More than 28 percent of the deliveries were Medicaid-financed. Virtually all physicians who performed deliveries during the year (about 97 percent) had billed Medicaid for at least one delivery.

Because of this high percentage of "participating" providers, the evaluators recognized that counting Medicaid claims for delivery would not be an accurate way to measure access to obstetrical care in the state. Evaluators needed to examine the physicians' level of effort before they could arrive at a true measurement. This study revealed that 13 percent of the physicians had performed half of all the Medicaid-financed deliveries in 1989. Only 3 percent delivered more than 100 babies to low-income women and about .8 percent, which equals eight physicians in the state, delivered more than 200 babies. Most of these deliveries occurred in university teaching hospitals and were billed by physicians who were supervising medical residents. This contrasted sharply with information on all deliveries in the state, which showed that 22 percent of physicians performed 100 or more deliveries and that 4 percent performed more than 200.

The third measurement revealed that only thirty-five of the approximately 1,000 physicians who delivered babies in 1989 did not perform any deliveries to low-income women, while twenty-three delivered solely to low-income women. Yet between those two groups no modal existed (i.e., there was no "usual" amount of low-income care that providers delivered in Washington during that year). From this, the evaluators identified a potential level of effort for participating providers that could help to evenly distribute the number of low-income patients each provider serves.

However, the evaluators realized that statewide averages are limited in their usefulness. Provider availability differs from county to county as do the insurance status and number of low-income women. The need to examine community-based data to achieve more meaningful insights on the availability of providers and the access problems women face was apparent. To do this, the evaluation team wanted to determine how many women traveled outside of the community where they lived to deliver their babies. Two important pieces of information were available on vital records—zip code of residence and zip code of delivery. A comparison of these data confirmed that a significant proportion of women were delivering in communities other

than the ones where they resided. This led the evaluators to conclude that half of the counties in Washington had provider shortages.

Closures of rural hospitals have caused serious access problems in the state. Clearly, many women were forced to go elsewhere to deliver because there was no hospital in the county where they lived. Reasons for this travel also included quality of care concerns and a lack of obstetrical providers. However, in many counties that have a hospital, women still traveled outside of the county to deliver. In all but one county, nonpoor women were more likely to leave their county of residence to deliver than were low-income women. The evaluators speculated that this may be due to greater access to transportation by more affluent women who travel to city hospitals. In the one county where low-income women left more frequently, the providers in that county were known to likely refuse to see Medicaid clients.

Another interesting finding of the study is the great variation among hospitals in the proportion of care they deliver to low-income populations. In rural counties, deliveries of low-income infants account for about 50 percent of the hospitals' care. Again, one reason for this high rate is that many higher income women travel to cities to deliver. In rural counties with more than one hospital, the study found that low-income deliveries were distributed fairly evenly among them. However, in urban areas of the state, low-income deliveries were disproportionately distributed among hospitals. Not surprisingly, the highest rates of low-income deliveries were found in teaching hospitals.

The evaluation team at the University of Washington is excited about the information they are gathering from their studies. Although data were available only from the first year, the evaluation has revealed some useful information for policymakers. Most notably, the preliminary evaluation has revealed that a dichotomous definition of provider participation has virtually no meaning when trying to measure access. Furthermore, the evaluators have determined that statewide averages are not very useful. Individual communities have very different problems with access that must be accounted for when developing policy. The evaluation has revealed that in some communities the supply of providers rather than their participation is the overriding problem. In others the problem is one of participation because physicians exclude low-income women from their practice. Other communities have problems with provider distribution.

Recognizing that looking at deliveries in isolation is insufficient, the evaluators will next examine the provision of prenatal care. Now that the evaluation has identified which providers deliver low-income infants and the number they deliver, the study will begin to track how much prenatal care is provided. It is expected that this information will give an even more accurate picture of provider availability and access to care in Washington.

Conclusion

Studies of provider participation are proving that simple counts of providers with a Medicaid billing number produce data that are of limited use to policymakers. Patient access to providers is much more important. Unless evaluations take into account all systems of care, the participating physicians' level of effort, and the diverse needs of individual localities, meaningful measures of physician participation cannot be ascertained.

"Far too often, those of us in federal and state governments focus solely on those services financed and delivered through the public sector and forget that most people in this country receive their care through the private sector. While governments are major buyers of health care, there are many other large purchasers who have influence over how health care is provided. As a nation, we deserve a basic health care system that meets our needs, and everyone in both the public and private sectors should accept the responsibility for developing the energy and resources necessary for producing such a system."

David Heppel
Director
Division of Maternal, Infant, Child, and Adolescent Health
Maternal and Child Health Bureau
Health Resources and Services Administration

"Pressing economic and demographic realities are forcing companies to focus on family issues. Skyrocketing health care costs, concerns about the productivity of the workforce, the increasing number of women entering the workforce, changing lifestyles, and the high rate of babies born at low birthweight have all been identified as factors that are causing employers to rethink their benefit plans and company policies in ways that we never have before. There are a lot of things going on in the private sector. Some of it is altruistic, and some of it is because it makes good business sense."

Liz Cronin
Manager of Health and Welfare Plans
Levi Strauss & Co.

States are not alone in their efforts to fight infant mortality. Many private companies across the country have special initiatives aimed at ensuring that employees have access to high quality and appropriate prenatal care. For example, Levi Strauss & Co., which paid for the delivery of more than 700 infants in 1990, recently began offering its employees a program called Healthy Beginnings. Administered through the Aetna Insurance Company, the program assists pregnant women by providing nursing consultation and follow-up services. Closely resembling many of the care coordination strategies instituted by states, women are assessed for certain risk factors during an initial telephone contact. If the woman does not have a doctor, the nurse will follow up with her every two weeks until one is identified. Women at low risk for bad birth outcomes are called again at the beginning of their second trimester and then at twenty-four weeks for reassessment. High-risk women are called every two weeks. Nurses answer any questions the women may have and discuss problems they may be encountering. They also regularly remind the women to tell their doctor of any changes during pregnancy. Postpartum calls are made to all participants. The program is voluntary but does provide a $100 cash incentive for those who participate and complete a questionnaire. Levi Strauss & Co. feels that the $160,000 annual cost of the program is a wise investment.

3. Assessing the Results of Prenatal Care Reforms

States have made significant reforms to their prenatal care benefit packages in addition to increasing Medicaid eligibility thresholds, streamlining the eligibility process, and developing outreach campaigns. Recognizing that low-income pregnant women need many services beyond traditional medical care, thirty-eight states have enhanced the scope of Medicaid-covered services (see Table 2). Working collaboratively, state Medicaid and Maternal and Child Health program officials have developed special initiatives that extend many support services such as care coordination, nutritional and psychosocial counseling, health education, and home visiting to women at risk of adverse birth outcomes.

Now that states have many of the reforms in place that are needed to improve birth outcomes, they face the challenge of evaluating the impact of their perinatal programs. Such evaluations will provide policymakers with valuable feedback on the key elements of an effective perinatal program.

The Challenge of Perinatal Evaluations

To meet the growing demand for public accountability in new perinatal programs, the field of evaluation has evolved over the last several years. Exciting developments in data linkages have occurred. Research that focuses on the process of service delivery and not strictly on outcomes has been developed. However, many questions remain and many issues must be resolved before strong evaluations can be conducted. There are many varied and complicated reasons why good, strong evaluations are impeded.

- **Defining Interventions.** Because many states initiated several reforms simultaneously, it is difficult for evaluators to identify which intervention produced the desired results. As programs are developed and evaluations are planned, evaluators must be given clear instructions on the specific policy questions that are of interest. This will help ensure that the evaluation produces appropriate answers to guide program development.
- **Comparing Programs.** Because of significant differences among states' health programs, it is nearly impossible to make comparisons across states. Consequently, evaluators must identify other ways to study changes. One such method is a pooled time series across states in which changes are studied at whichever point of time they occurred. However, because of the possibility that other factors may influence the results in addition to the defined interventions, the appropriateness of these studies must be reassessed.

Table 2
States With Medicaid-Covered Enhanced Prenatal Care Services

State	*Care Coordination/ Case Management*	*Risk Assessment*	*Nutritional Counseling*	*Health Education*	*Psychosocial Counseling*	*Home Visiting*	*Transportation*
Alabama	■	■		■		■	
Alaska	■	■	■			■	
Arizona							
Arkansas	■	■	■	■	■	■	
California	■	■	■	■	■	■	
Colorado							
Connecticut		■		■		■	
Delaware	■	■	■	■	■	■	
District of Columbia							
Florida							
Georgia	■	■		■		■	
Hawaii	■	■	■	■			
Idaho	■	■	■		■	■	
Illinois	■	■					
Indiana	■	■				■	
Iowa	■	■	■	■	■		
Kansas		■	■	■		■	
Kentucky							
Louisiana	■	■					
Maine							
Maryland	■	■	■	■	■	■	
Massachusetts	■	■	■	■	■		
Michigan	■	■	■	■	■	■	■
Minnesota	■	■	■	■	■	■	
Mississippi	■	■	■	■	■	■	■
Missouri	■	■					
Montana	■	■				■	
Nebraska							
Nevada	■	■	■	■	■	■	
New Hampshire	■	■	■	■	■	■	
New Jersey	■	■	■	■	■	■	
New Mexico	■						
New York	■	■	■	■	■	■	
North Carolina	■	■		■		■	
North Dakota							
Ohio	■	■	■	■	■	■	
Oklahoma							
Oregon	■	■	■	■		■	
Pennsylvania	■	■	■	■	■	■	
Rhode Island							
South Carolina	■	■	■	■	■	■	
South Dakota							
Tennessee	■	■				■	
Texas	■	■					
Utah	■	■	■	■	■	■	
Vermont	■					■	■
Virginia	■	■	■	■		■	
Washington	■	■	■	■	■	■	■
West Virginia	■	■	■	■		■	■
Wisconsin							
Wyoming							
Total	36	36	25	27	19	30	5

SOURCE: National Governors' Association, *MCH Updates*, July 1991.

- **Politicizing Evaluations.** Especially in the area of infant mortality, where the bottom line has such import, the evaluation process can be influenced by politics. Too often officials are quick to jump to the conclusion that the infusion of new dollars for a new program has resulted in improved birth outcomes, even when a strong evaluation does not support this conclusion. Evaluators must be cautious and not allow the politics of an issue to weaken or compromise their study process.
- **Using Medicaid Data.** It is widely recognized that Medicaid claims files contain valuable information. However, most states experience significant problems in accessing and using these data. Staff with expertise in accessing and linking Medicaid data with other data systems are greatly needed.
- **Measuring Impacts Beyond Birth Outcomes.** Because so many evaluations focus on birth outcomes rather than the provision of services, very little is known about the impact of perinatal reforms on the delivery system. For example, what happens to a clinic's ability to provide services when increasing numbers of women are given access to that clinic? Evaluations have not typically incorporated these sorts of measurements.

These issues present formidable challenges for program evaluators, and forming a partnership that includes program officials and policymakers can be critical to addressing many of them. Strong evaluations need to begin at the same time that program planning is initiated. This will help ensure that the evaluator studies those variables, including intermediate variables, that are important for policy development and decisionmaking. Three states that have formed such a partnership and begun to assess the impact of their perinatal initiatives are Rhode Island, Utah, and North Carolina. Although it is too early to see significant changes in infant mortality rates, these states have put much energy into evaluating both process and outcome data. Initial results from these programs are promising.

Rhode Island's RIte Start Program

Operational since January 1988, Rhode Island's RIte Start program provides maternity care coverage to uninsured women who are not eligible for Medicaid and who have incomes below 200 percent of poverty. The program helps close the gap left between Medicaid and private insurance coverage but also provides important support services to both Medicaid and RIte Start recipients. A toll-free hotline is coupled with ongoing outreach, care coordination services for high-risk pregnant women, childbirth preparation and parenting classes, and smoking cessation programs. RIte Start staff also provide training and technical assistance to prenatal care providers and Medicaid staff. This helps ensure that information is shared and referrals are made among all those who come into contact with pregnant women in the state. Several studies measuring both the process and outcomes of the new program have been undertaken by Rhode Island. These studies are showing that the program is reaching the target population, increasing enrollment in Medicaid, and having a positive impact on birth outcomes.

Evaluating Process Data. The state first wished to determine whether its program was reaching the target population. An analysis of the demographics of all RIte Start enrollees during the first two years of the program (1988 and 1989) revealed that

the program was reaching an at-risk population that included teenagers, minorities, and the uninsured working poor. Specifically, the results indicated that:

- The majority of the women were below age twenty-five; 20 percent were teenagers.
- Half of the enrollees were unmarried.
- Almost a third of the participants were in families with an annual income of less than $5,000. More than half had annual incomes under $10,000, and more than 80 percent had annual incomes of less than $15,000. Although many of these women's annual incomes are below the Medicaid eligibility threshold, they remained ineligible for the program because many were teenagers living at home, seasonal workers who earn more than the monthly threshold at various times during the year, or ineligible aliens.
- The majority of enrollees were minorities; 32 percent were black and 30 percent were Hispanic. Many of the women were recent immigrants who could not speak English and seemed to be fearful of government programs.
- Two-thirds of the women had not completed high school.

RIte Start also seems to be well-received by its participants. Ninety-seven percent of those surveyed expressed satisfaction with the program, describing it as helpful or very helpful.

Evaluating Outcome Data. An analysis of the birth outcomes for the 667 women enrolled in RIte Start during the first year indicated that 649 had live births. Six percent of the babies were born at low birthweight and .9 percent were born at very low birthweight. Although the RIte Start participants are high-risk, the low-birthweight rate of this population was the same as the statewide average. When compared with a control group of women with similar socioeconomic characteristics, that rate is more favorable. (The comparison group had an 8.4 percent incidence of low-birthweight births). RIte Start participants also have a much lower incidence of ceasarean deliveries—18.1 percent, compared with a statewide rate of 22.3 percent.

The program also has had a positive impact on the level of uncompensated hospital maternity care. Bad debt for obstetrical care declined by nearly $500,000 during the first six months of 1988 in one hospital, which delivers 68 percent of all infants in Rhode Island. The introduction of the RIte Start program during this time appears to be the only significant factor that could explain this 59 percent decrease in lost obstetric service revenues.

Probably the biggest success of the RIte Start program has been the positive impact it has had on Medicaid. About 1,000 women were referred to Medicaid during the first year of the program. RIte Start staff discovered that while the state had adopted eligibility expansions, many of the eligibility workers were not initially aware of these changes. Much collaboration between the Medicaid agency and Health Department has resulted, and eligibility workers across the state now understand their role in providing access to prenatal care. Moreover, women who call the hotline and who are referred to Medicaid are tracked. If their eligibility is denied, the women are instructed to mail a

copy of the denial to the Health Department. RIte Start staff then follow up on those denials that seem inappropriate.

Rhode Island is pleased with the success of the program. The state has discovered that a very small minority of women actually need the financial coverage that RIte Start provides. Most simply need help accessing the Medicaid coverage to which they are entitled. Through interagency collaboration a strong relationship between the Health Department and the Medicaid agency has developed. Referrals between the programs have greatly increased, and pregnant women in Rhode Island are now virtually assured of coverage for needed maternity care.

The state is in the process of building upon the success of the RIte Start program to improve health care coverage of children. A new initiative provides on-site, pre-eligibility screening and referral at community health centers, hospitals, and public health clinics for a variety of health and nutritional programs, including Medicaid, RIte Start, WIC, and Food Stamps.

Utah's Baby Your Baby Program

Utah also has implemented significant perinatal reforms. In addition to removing many financial and eligibility barriers, the state also provides prenatal care coordination and expanded services such as nutritional assessment and counseling, psychosocial assessment and counseling, and prenatal education to pregnant women.

Following these changes, Utah began a major media campaign—Baby Your Baby—to inform women of the importance and availability of early and continuous prenatal care. Aspects of this campaign include:

- Television and radio public service announcements;
- Documentaries;
- Brochures, bus placards, and other printed materials;
- A coupon book for women who enter care in their first trimester and continue to receive care throughout their pregnancy; and
- A toll-free hotline.

Utah has been closely monitoring the program to determine its effectiveness in raising public awareness of the infant mortality problem and to assess whether birth outcomes have been impacted. The state has especially focused on calls made to the hotline as a measurement of the program's visibility. Thus far more than 39,000 calls have been received. A steady increase in the number of calls has been seen during the first four years: in 1988 there were 1,700 calls (a monthly average of about 155); in 1989 10,268 calls were received (averaging about 856 per month); in 1990 the hotline received 11,583 calls (a monthly average of about 965); and in 1991 more than 16,000 calls were made to the hotline (averaging about 1,333 per month). Utah also was interested in evaluating the processes as well as the outcomes of the Baby Your Baby program. Highlights of the evaluations are presented below.

Evaluating Process Data. Because the Baby Your Baby campaign is such an important aspect of the perinatal initiative, the state was particularly interested in

assessing the appropriateness of the outreach methods it had chosen. A survey of hotline callers found that 65 percent made the call after viewing a televised public service announcement (PSA). Thirty-two percent were referred to the hotline by a physician, friend, or clinic. Another study focused on the effect of PSAs on hotline calls. Not surprisingly, this study revealed that PSAs played in the early morning hours had very little impact on hotline calls and that those played during prime time generated the most calls. Nevertheless, for virtually every time slot an increase in calls in the fifteen minutes following the televised announcement was noted.

The state also wanted to determine whether it was reaching the target population. Surveys of hotline callers revealed that nearly 50 percent of the calls were made by women in their first trimester; 27 percent made the call within the first eight weeks of their pregnancy. Other studies suggest that callers to the hotline may represent more high-risk populations. For example, more than one-fourth of the calls were from teenagers. This is significant because the percentage of babies born to teenagers is only 9 percent statewide. Of the women who called the hotline, a greater percentage were unmarried and less educated compared with other women in the state giving birth.

The state has been especially interested in assessing the growth in the Medicaid program to evaluate whether more low-income women are obtaining financial access to care. Medicaid deliveries increased from 4,495 in 1987 to an estimated 10,392 in 1991. Although this increase is largely due to expansions in the eligibility thresholds, the actual number of deliveries exceeded the projections made by the Department of Health. Outreach seems to be very successful since nearly all women estimated to be living in families with incomes of less than 133 percent of poverty are enrolled in Medicaid.

Evaluating Outcome Data. Utah also has undertaken studies to assess the impact of outreach efforts, eligibility expansions, and service enhancements on birth outcomes. Hotline calls made during an eighteen-month period were matched with birth certificates by using the mother's name and date of birth, which were obtained from the hotline database. Nearly 80 percent of the calls were successfully matched to birth certificates. Births that were not matched to a hotline call during the same period were used as a control group. Thus one study took into account 67,882 births; 6,174 babies were born to women who had made a call to the hotline during pregnancy and 61,708 babies were born to women who had not called the hotline. Finally, these births were matched with Medicaid-paid claims files to compare the average cost of babies born to women calling the hotline with the cost of babies born to women not calling the hotline.

- Baby Your Baby hotline callers initiated first trimester care more frequently than did pregnant women who did not call the hotline (86 percent compared with 81 percent).
- Although the average birthweight of babies born to women who called the hotline is slightly lower (3,307 grams) than that of babies born to women who did not call the hotline (3,331 grams), the average cost of delivery is lower for women who called the hotline ($2,016 for hotline callers, compared with $2,300 for non-hotline callers).
- Seventy-eight percent of teenagers who made a call to the hotline received prenatal care in the first trimester, compared with 64 percent of pregnant teenagers who did not call the hotline.

- Baby Your Baby hotline callers who were teenagers had a lower percentage of low-birthweight babies (7.1 percent) than did their peers who do not call the hotline (9 percent).

Because of the success of the Baby Your Baby program, Utah has decided to expand the program to focus on young children. New media materials have been developed that emphasize the importance of preventive care for children. The state will continue to monitor the perinatal and child health programs to assess their effectiveness.

North Carolina's Baby Love Program

Undoubtedly one of the most ambitious state studies is the one being undertaken in North Carolina to evaluate the effect of its Baby Love program. Implemented on October 1, 1987, the perinatal initiative includes a significant broadening of Medicaid eligibility, strategies to make the eligibility system easier to access, outreach efforts, Medicaid coverage of important support services, and a maternity care coordination system.

At the time of initial planning of these reforms, the state also began planning a strong evaluation and quality assurance component. The evaluation was desired for two important reasons. One was to gather information to identify county-specific and statewide gaps in services. Second, the state wanted to evaluate both the processes and outcomes of the program by looking at the effectiveness of specific interventions.

Two existing data collection and analysis systems have aided in the evaluation of the Baby Love program. One is the Health Services Information System (HSIS), which automatically collects information on patient characteristics, service utilization, Medicaid billing, and pregnancy outcome data from all the local health departments. By making a few changes to this reporting system the evaluators also were able to collect information on maternity care coordination, receipt of WIC, receipt of child care and family planning services, as well as information on client needs and receipt of needed services. The other system is the State Center for Health Statistics, which has the ability to match and analyze vital statistics and program data files with a high degree of sophistication.

Working with evaluators, program officials also developed two new data collection tools to help identify gaps in services. The first was a maternity problem documentation log, which quantified data gathered by maternity care coordinators to establish where changes needed to be made in eligibility, financing, and service delivery. Second, a survey was developed to identify those outreach methods most effective in reaching the target population.

Identifying Gaps in Services. The documentation log provided a snapshot of existing problems in the state's health and social services systems. This enabled program administrators to make needed changes in teen eligibility, newborn verification procedures, and transportation policies. By revealing that 75 percent of the clients learned about the program from professional staff at various local agencies, the outreach survey informed project staff that the community agency database, which was one aspect of the outreach strategy, was an appropriate effort. Furthermore, the outreach survey revealed that 60 percent of the women participating in the Baby Love program

had not been enrolled in Medicaid prior to the expansion. This assured the staff that they were reaching the target population.

Evaluating Process Data. Evaluators began to study process data once the Baby Love program was operational. Medicaid eligibility files were examined to determine whether the target population had been successful in completing the eligibility process. Data showed that actual program enrollment exceeded estimates for the first three years of the program.

Another area in which the evaluation focused was the development of a statewide system of care coordination. In year one of the program, eighty-three out of 100 counties initiated the care coordination program. In year two, the number of counties increased to ninety-five, and by year three, ninety-nine counties had implemented care coordination. The number of clients receiving care coordination services expanded rapidly from 9,120 by June 1989 to 14,033 by June 1990. Currently, 58 percent of the eligible Medicaid population is receiving these services.

The evaluators then focused on service utilization. Because maternity care coordination is viewed as the cornerstone of the Baby Love program, the evaluators were especially concerned with assessing the impact of the receipt of care coordination on service utilization. Information collected through the HSIS revealed that in virtually every area, service utilization improved among the population who had received care coordination services from local health departments. The following data from calendar year 1990 document the successes:

- Sixty-six percent of the women receiving care coordination had nine or more prenatal visits, compared with 54 percent of the group who did not receive care coordination.
- Eighty-eight percent of women receiving care coordination participated in WIC, compared with 72 percent of those who did not receive care coordination.
- Sixty-eight percent of the women receiving care coordination received a postpartum examination, compared with only 43 percent of the group who did not receive care coordination.
- Sixty-six percent of the infants born to women enrolled in maternity care coordination received a well-child visit, compared with 25 percent of the infants whose mothers did not receive care coordination.
- Nearly 82 percent of the infants whose mothers received care coordination received WIC, compared with 40 percent of those whose mothers were in the non-care coordinated group.

Evaluating Outcome Data. The provision of maternity care coordination services clearly had a positive impact on service utilization. But did this also translate into positive birth outcomes and lower costs? To answer these questions the evaluators matched birth certificate records with Medicaid newborn claims, claims paid for maternity care coordination, and records from HSIS and WIC to gather information on outcomes, costs, and services. Preliminary findings from these data matches revealed that women who received care coordination services experienced better birth outcomes

compared with those Medicaid-eligible women who did not receive these services. Highlights of these data include:

- Medicaid-eligible women who did not receive care coordination had a 21 percent higher incidence of low-birthweight babies than a similar group of women who did receive the care coordination.
- Very low-birthweight babies were born at a rate 62 percent higher to those women not receiving care coordination services than were born to women who did receive the services.
- Infant mortality occurred at a rate 23 percent higher if the mother did not receive care coordination during pregnancy.

To ensure that other factors were not influencing the birth outcomes, the evaluators controlled for factors such as maternal characteristics and whether the care was provided through the health department or another provider. In both cases the data were similar; women receiving care coordination delivered healthier babies. Furthermore, the evaluators examined the length of time pregnant women received care coordination and discovered that women receiving care coordination longer had better birth outcomes. To ensure that a preterm delivery shortening the length of participation did not bias the results, the evaluators compared birth outcomes with the percentage of pregnancy during which care coordination was provided. Women who received care coordination for more than 50 percent of their pregnancy had substantially lower rates of low birthweight, very low birthweight, and infant mortality. Even for women receiving the least amount of care coordination, results were better using every measure.

Providing care coordination to pregnant women in North Carolina is proving effective in reducing adverse birth outcomes. Furthermore, the data are showing that maternity care coordination is cost-effective. For every dollar spent on maternal care coordination, Medicaid has saved $2.02 in newborn medical costs. Officials estimate that they have saved $2,174,000 during the first two years of the program.

This evaluation has been critical to the program's success. Not only has it helped program officials identify areas that need to be improved such as outreach efforts and public education, but the results of the evaluation also enabled them to provide solid evidence to support funding requests. The positive results convinced the North Carolina General Assembly in 1990 to broaden Medicaid eligibility to 185 percent of poverty, to provide up-front funding to expand the maternity care coordination system, and to continue to support North Carolina's efforts to further reduce the infant mortality rate.

Conclusion

Clearly, the prenatal reforms instituted by Rhode Island, Utah, North Carolina, and other states have had a positive impact on women's access to maternity care and birth outcomes. However, policymakers must recognize the limitations of any reform initiative. Financial access to perinatal care is only one component of the complex problem of infant mortality. The assumption that limited access to health care is the cause of bad birth outcomes is misleading, and consideration should be given to the strong social component of this problem. The impact of poverty on birth outcomes may be larger than

that of health care. Perinatal care is necessary but it very well may not be sufficient to overcoming infant mortality. Caution should be exercised so that the benefits of health care interventions are not oversold.

Program officials also must consider the capacity of public programs such as Medicaid to reach all women in need. For example, in many states new perinatal programs are achieving great results, but the overall infant mortality rate has not significantly improved. The ability to reach everyone in need with a sufficient amount of services is limited. Program officials, policymakers, and evaluators must be aware of this limitation and base assumptions accordingly.

Although evaluations have produced some exciting information, including higher enrollment rates than estimated, correlations between improved birth outcomes and new programs, and decreased costs associated with new initiatives, much more data are needed. Evaluating public programs is difficult. People cannot be randomly assigned to comparison and control groups. Similarly, communities cannot be restricted from implementing a new initiative solely for the purpose of research and analysis. Because the environment cannot be controlled, evaluators have much more trouble in deciphering the truth. Many states are undertaking this difficult but very important task because it is critical that funds be invested in effective programs. Conducting perinatal evaluations presents many challenges that evaluators, program officials, and policymakers—working in partnership—must address to ensure wise investment of public resources.

II. Improving Children's Health Care Programs

"The litany of problems facing today's children is extremely disturbing. In 1989 the number of children reported as abused or neglected was twice the number reported in 1980. State foster care rolls are increasing at an alarming rate. The high number of babies exposed to drugs and other substances during pregnancy is putting a strain on child welfare and health programs. Low-birthweight rates have been stable for more than ten years. Immunization rates are down. Of the more than 30 million Americans who are uninsured, between 9 million and 11 million are children. More than two-thirds of these children live in families with incomes below 185 percent of the federal poverty level. If current trends continue, one in four children will be living in families with incomes below the federal poverty level. These are distressing factors by anyone's standards. Members of the House and Senate are determined to tackle these problems head on despite the fact that we are working within a very constrained budgetary environment.

"Everyone working in the states must be congratulated for raising the visibility of children and child health at the national level. Without your efforts, we would not be able to go forward and address these very serious problems."

Marina Weiss
Chief
Health, Income Security, Social Services Section
Senate Finance Committee

4. Designing a Model Child Health System

The Omnibus Budget Reconciliation Act of 1986 provided the impetus for states to focus significant energy and resources on the design and implementation of ambitious infant mortality reduction initiatives. These programs not only have expanded financial access to health care, but also have ensured coverage of appropriate nonmedical support services. As discussed in the previous chapters, initial evaluation data suggest that pregnant women and their infants have benefited from these creative efforts. However, the legislation that prompted states to expand Medicaid coverage of poor and near-poor pregnant women and infants has not stimulated a commensurate level of activity on behalf of children.

This changed dramatically with the passage and subsequent implementation of the Omnibus Budget Reconciliation Acts of 1989 and 1990. OBRA-89 required all states to set minimum Medicaid income eligibility thresholds at 133 percent of the federal poverty level for children below age six. OBRA-90 further expanded coverage by requiring states to phase in, one year at a time, coverage of all children up to age nineteen living in families with incomes below 100 percent of poverty.

Other provisions in OBRA-89 are intended to improve the quality of care provided to children. The law requires states to spend at least 30 percent of their Maternal and Child Health block grant funds on preventive and primary care for children and an additional 30 percent of funds on the care of children with chronic or disabling conditions. Even more important, the law made sweeping changes to Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program—changes that liberalize policies relating to the provision of preventive health and developmental examinations, the participation of providers, and the coverage of primary, acute, and specialty services.

While improving programs for pregnant women has proven to be a significant challenge for states, improving programs for children may be an even more formidable task. Rather than dealing with a specific condition over a finite period of time, states must try to improve and develop programs that can meet a wide range of needs—preventive, primary, acute, and chronic—throughout childhood and adolescence.

Critical Elements of a Model Child Health Program

Many of today's children and families experience problems of tremendous complexity, which are caused by a combination of health, educational, social, environmental, economic, and cultural factors. For a growing number of America's children, childhood is characterized by poverty, dysfunctional families, lack of social supports, poor

schools, family violence, and abuse. Many children become locked into a cycle of disadvantage in which health problems are endemic.

Developing child health prevention programs that can address the complex problems confronting many children is very difficult. Yet in this era of fiscal constraints and scarce resources, programs that include a wide range of interventions aimed at preventing serious illness are necessary. These preventive programs need to possess many components, including appropriate services tailored to the specific community in which they will be offered, strong outreach services, and broad public education.

Many studies have documented the needs of children. Initiatives designed to address the specific needs, resources, and service gaps in the communities for which they are intended have proven to be the most effective. Policymakers must have considerable knowledge of the health needs of the community before designing a program to serve that community. Moreover, once the needs and resources to meet those needs have been identified, strategies to enable clients to access the system must be developed.

For many years it was assumed that if a well-designed, comprehensive system were put into place, needy clients would flock to it. This assumption has not held true. A growing recognition of the importance of public education and outreach has resulted in the inclusion of such strategies in new programs. Outreach is more than mere notice of the program. It includes addressing the basic needs of patients, for example, by arranging transportation to and from scheduled appointments and by offering health facility operating hours that do not conflict with work or school commitments.

Conclusion

Much as OBRA-86 acted as a catalyst for states to reform their perinatal programs, recent federal legislation has encouraged states to direct their efforts toward improving child health programs. In 1990 the National Governors' Association conducted a Survey of Children's Health Initiatives to gather information on state efforts to improve health programs for this population. The study focused on many different aspects of children's health care, such as strategies for improving access to care by streamlining Medicaid eligibility systems, implementing outreach campaigns, and increasing pediatric participation. The NGA study also included a comprehensive look at states' efforts to modify preventive health and developmental screens, provide treatment services mandated by OBRA-89, and develop strategies to coordinate services and integrate a host of health-related services to children.

Caring for Kids: Strategies to Improve Child Health Programs, the report developed from the survey results, documents that although innovative strategies to address children's health needs are beginning to be implemented, states are continuing to struggle with the challenge of developing comprehensive programs.

Ensuring that all children grow up to be physically, mentally, and socially healthy will require considerable effort. In particular, it will require that programs incorporate multiple interventions to address multiple needs, take into account the specific needs, resources, and service gaps in specific communities, and include broad outreach services.

5. Improving Children's Access to Care

The first step in building a comprehensive child health program is ensuring that all children have access to health services. With the passage of recent legislation expanding Medicaid coverage, financial access for many low-income children has been virtually assured.

States now are faced with the challenges of informing families of expanded benefits and of making the enrollment process easy and accessible. The National Governors' Association's Survey of State Children's Health Initiatives revealed that the majority of states have not enrolled potentially eligible children. There are numerous reasons why children's enrollment in Medicaid is lagging. Many families do not understand the importance of preventive health care. Furthermore, complex Medicaid application procedures and inadequate marketing and outreach campaigns directed toward children have contributed to this problem.

States now are beginning to address these barriers by initiating public awareness campaigns and streamlining the eligibility process for children. For example, Utah has developed a mass media outreach campaign to advertise the importance of preventive child health care using its successful Baby Your Baby logo and identity (see Chapter 3 for a more detailed description of this program).

Similarly, many of the eligibility streamlining strategies that states have used successfully to enroll pregnant women in Medicaid are being used for children. For example, most of the states that review eligibility based on a shortened application form use this form for both pregnant women and children. Outstationing eligibility workers at pediatric sites is another strategy being used in a growing number of states. Other strategies include allowing families to submit applications by mail and enrolling infants before their mothers' sixty-day postpartum eligibility period expires. As states begin to adapt outreach efforts and streamlining strategies that have proven successful in enrolling pregnant women, Medicaid enrollment rates for children should increase.

As increases in enrollment do occur, states also must ensure that enough providers are available to serve the growing number of Medicaid-eligible children. Medicaid and Maternal and Child Health administrators historically have had excellent relations with pediatric providers. Pediatricians tend to be more public-health oriented than other physician specialists, and public officials often credit them with being more altruistic in their willingness to serve low-income populations. However, recent studies indicate that the number of pediatric providers willing to care for Medicaid-eligible children may be shrinking.

A 1988 American Academy of Pediatrics report found that the percent of pediatricians willing to serve all Medicaid clients who enter their office decreased from

85 percent in 1978 to 77 percent in 1989. Also documented in the study and closely related is the increase from 25 percent to 39 percent in the proportion of pediatricians willing to accept only some Medicaid patients.

The 1991 NGA study generally supports these findings. While twenty-one states reported no problems with pediatric participation, eleven believed that there was a growing pediatric participation problem and eleven responded that a problem with pediatrician participation currently existed. When asked to report the reasons pediatricians typically give for not participating, state officials cited many of the traditional complaints that are often lodged against the Medicaid program. As indicated in Table 3, inadequate payment levels is the overriding reason.

Although many states do not indicate a serious problem with pediatric participation in Medicaid, most states are aggressively pursuing initiatives to ensure that provider participation levels do not become critically low. According to the NGA Survey of State Children's Health Initiatives, thirty-eight states have begun outreach efforts to assist in the recruitment and retention of pediatric providers. Additionally, thirty-one states have raised fees for pediatric services or are planning to do so. Some states also are implementing creative fee schedules not only to improve participation, but also to improve the quality of care provided in their programs. Two states that have used this strategy are New York and Michigan.

Development of a Special Provider Program in New York

In October 1990 New York implemented the Preferred Physicians and Children program to respond to several disturbing trends. One was a problem with pediatricians unwilling to deliver services through the EPSDT program. In fiscal 1989 the state had only a 15 percent EPSDT participation rate, though 51 percent of children on Medicaid had received a primary care visit. Furthermore, although the state had many participating pediatricians, most appeared to be restricting their Medicaid caseloads. Forty-four percent of the physicians had less than one Medicaid visit per week and 19 percent had two or less. The state also was concerned about the growing problem of Medicaid mills (i.e., high-volume providers who serve Medicaid patients without any plan of care and limited credentials). To address these problems the new program was developed with two main objectives: to increase participation among primary care physicians in Medicaid and to increase the number of Medicaid-eligible children receiving primary care services, especially through EPSDT.

The new program provides higher reimbursement for physicians meeting certain eligibility and practice requirements. An advisory committee of practicing physicians was formed to assist the Medicaid agency in designing the new program. Specifically, this group decided on the following criteria for participation in the Preferred Physicians and Children program. Participating physicians must:

- **Have Active Hospital-Admitting Privileges.** Because physicians must maintain a certain standard of care in order to obtain and keep hospital-admitting privileges, this requirement ensures a level of quality. It also ensures that preferred physicians will have the capacity to coordinate inpatient care with outpatient services. A waiver system has been set up to

Table 3
State Reporting of Principal Reasons for Pediatric Provider Nonparticipation

Reasons for Not Participating	*Number of States*
Low/Inadequate Fees	36
Excessive Paperwork/Administrative Burden	30
Problems with Clients	21
Delayed Payments	14
Malpractice Liability	3

SOURCE: National Governors' Association, Survey of State Children's Health Initiatives, 1990.

allow physicians who may live too far away from hospitals to maintain admitting privileges to be eligible for the program.

- **Be Board-Certified.** This requirement also helps ensure quality. Physicians who are board-eligible for no more than five years after completion of postgraduate training also are eligible.
- **Provide Twenty-Four-Hour Coverage.** To ensure that participating physicians can provide a medical home for the children they serve, there must be an on-call physician available by phone at all times. Recorded messages directing families to the emergency room are not acceptable.
- **Provide Medical Care Coordination.** To ensure continuity of care, physicians participating in the program must agree to share information with other providers rendering care to their patients and to follow up on patient visits to specialists.
- **Be in Good Standing.** This is another quality of care component of the program.

Increased fees have been instituted for physicians participating in the program based on an alternative reimbursement methodology that moves away from a specialty bias. New reimbursement rates reflect the cost of the service delivered, regardless of who is rendering the service. Competitive with other third-party payors in the state, fees for well-child visits in the Preferred Physicians and Children program range from $44 to $50 in New York City and from $36 to $42 in upstate New York.

The program was first implemented on a pilot basis with fifty physicians. To ensure its success the Medicaid agency offered much support to the physicians' office staff so that claim denial rates were kept to a minimum. After overwhelmingly positive results, these physicians then became ambassadors for the new program. A letter announcing the new program was jointly signed by the deputy commissioner of the Medicaid agency and the presidents of the state chapters of the American Academy of Pediatricians and the American Academy of Family Physicians. Physicians who had participated in the pilot were requested to present the program at local chapter meetings, and articles appeared in provider publications.

All of these efforts have paid off. After only seven months the program has enrolled 1,500 physicians; 58 percent are pediatricians, 18 percent are family prac-

titioners, and 20 percent are specialists. Not surprisingly, only a small percentage of these physicians are new Medicaid providers. Anecdotal information from counties suggests that some physicians who had stopped serving Medicaid patients have opened their practice back up in order to participate in the Preferred Physicians and Children program. Nonetheless, the state is planning to concentrate on recruitment efforts in targeted areas around the state. Additionally, the state's fiscal intermediary will begin marketing the program.

The state is excited and optimistic about the program's success. In the future, New York hopes to merge the program with the state's managed care initiative. The state believes that these two initiatives will help ensure that children in New York will have access to comprehensive, high-quality care.

Creation of a Two-Level Provider System in Michigan

Like several other states, the EPSDT program in Michigan is jointly administered by the Department of Public Health and the Medicaid agency. (See the following chapter for a more detailed discussion on EPSDT program management strategies.) For many years only local health departments that met stringent eligibility criteria, which focused heavily on standard equipment, supplies, and the content of the exam, were allowed to conduct screenings. While the state was assured that children received only the highest quality screens through EPSDT, the limited number of screening providers resulted in limited access to screens for children. In the last several years, the two agencies have worked collaboratively to improve provider participation in the screening portion of the EPSDT program in an effort to improve access to these services. At the same time, the two agencies have tried to maintain quality in the program. These efforts were further enhanced by the enactment of OBRA-89 EPSDT provisions, one of which explicitly prohibits states from excluding qualified providers from participating in the program.

Historically in Michigan local health departments were given grants to conduct the screening examinations under EPSDT. These entities also were responsible for doing outreach, scheduling appointments, and providing or arranging for transportation. Local health departments were required to meet certification criteria to be eligible for these grants. In 1987 the financing of the EPSDT screen was revised so that it became reimbursable on a fee-for-service basis. At the same time, the EPSDT system was opened up to allow private physicians to become screening providers. However, because the rigid certification process to become a screening provider was maintained, few private pediatricians enrolled. Even fee increases did not provide the necessary incentive to attract new providers. In fact, when OBRA-89 passed, only forty-seven private physicians were enrolled as EPSDT providers. Although children could receive diagnostic and treatment services from any Medicaid provider, many children did not have access to screens.

With the passage of the OBRA-89 provision that prohibits states from excluding providers from participating in the EPSDT program, Michigan decided to further open up the system by creating two levels of EPSDT screening: a new basic screen and a comprehensive screen. The basic EPSDT screen can be conducted by any enrolled pediatric Medicaid provider, and components of the screen can be performed and billed for separately. Comprehensive EPSDT providers, on the other hand, are eligible for a

higher reimbursement rate. To qualify they must render the full EPSDT screen, including hearing and vision tests, at one visit. Although the basic structure of the old system was maintained for Comprehensive EPSDT providers, certification requirements were redesigned to be less stringent. These criteria now are very similar to those in New York's Preferred Physicians and Children program. In addition, new referral and follow-up requirements were instituted for Comprehensive EPSDT providers. This was due largely to the recognition that, except for certain urban areas, local health departments are not primary care providers. To ensure continuity of care, EPSDT screening providers now are required to provide any needed care or to arrange for its delivery.

Michigan planned to have the new system fully implemented by October 1, 1991. Much of the progress on the new EPSDT program has been stymied by serious budget problems. Fiscal constraints forced the Medicaid agency to cut by 20 percent the reimbursement rates to all providers. Obstetrical and pediatric provider rates subsequently were restored. It is expected that the new program will result in more children receiving quality EPSDT screens.

Conclusion

Financial access to child health programs has been greatly enhanced through OBRA-89 and OBRA-90 Medicaid eligibility expansions. To improve access for children, states also are beginning to build upon successful eligibility streamlining strategies and outreach efforts that have been directed toward pregnant women. OBRA-89 and recent studies indicating a reduction in pediatric participation have served as a catalyst for states to re-examine pediatric recruitment efforts in order to serve the growing number of eligible children. Many states also are using this opportunity to implement creative fee schedules that tie quality assurances with increased reimbursement in EPSDT programs. Through all these efforts it is expected that children's access to preventive care will improve significantly over the next few years.

6. Ensuring That All Children Receive Preventive Screens

Since its inception in 1967, the Early and Periodic Screening, Diagnostic, and Treatment program has embodied the principle that all Medicaid children should receive regularly scheduled examinations to detect health, vision, hearing, and dental problems, and if needed, further diagnosis and treatment of any identified ailments. EPSDT holds great promise for improving children's health care, though it is widely recognized that the program has not lived up to its potential. For example, despite the fact that the program includes an informing and outreach component, participation rates have been low. In 1989 states reported that only 39 percent of Medicaid-eligible children participated in the program. Yet because states are granted a great deal of flexibility in how they manage their EPSDT programs, there is much that can be done to encourage participation. The recent NGA study documented these various management approaches.

The survey found that thirty-two states administratively locate their EPSDT programs within the public welfare agency. Under a typical scenario an eligibility worker will go through the entire eligibility process with the family. After gathering all the required documentation and making the determination, the worker will then notify the family of their eligibility for the EPSDT program.

A number of states use a different approach. Nineteen states contract the general program management of EPSDT to an entity separate from the welfare agency. Under this arrangement family information is sent to contract staff. They then contact the family, explain the program, assess the family's needs, assist in arranging care, and in most cases, follow up with the family to ensure that the needed care has been obtained.

Officials in states where EPSDT administration is contracted to an agency separate from the welfare system expressed satisfaction with the program's management. However, a large proportion of officials in those states that have an eligibility-based system are not satisfied that it is the most effective way to administer the program. Many believe that it is difficult to provide an orientation to this important health care benefit when families are overwhelmed with information during the eligibility determination process. Furthermore, many believe that the capacity of an eligibility-based system to help families take advantage of the program is limited.

States have used the flexibility of the EPSDT program to develop creative management strategies to reach out to eligible children, inform them of EPSDT benefits, encourage their participation, and help guide them through the program. Three innovative program management approaches are described below.

Interagency Collaboration in California

The California Child Health and Disability Prevention (CHDP) program offers health screens to all Medicaid-eligible children, and through state-only funds, to children up to age nineteen living in families at or below 200 percent of the federal poverty level. CHDP, which includes the screening component of EPSDT, is located in the Department of Health Services (DHS) as is the Medicaid agency (Medi-Cal). Ensuring its success are formal interagency agreements at both the state level between DHS and the Department of Social Services, and at the county level between the welfare agencies that determine eligibility and the local health departments that run the CHDP program.

In California all applicants for Medi-Cal and AFDC who have family members below twenty-one years of age are informed about EPSDT, given an informational brochure, and asked if they would like to participate. This information is then sent to the local CHDP program. Followup occurs with all who have requested services. In many counties the CHDP staff also contact those families who have declined services. This may take the form of a telephone call, a letter, or a personal visit. Often it takes the form of all three. CHDP staff provide information about the importance of care and help arrange health screenings for the families. They also monitor children with special needs to ensure that those needs are being met.

Numerous strategies are used to ensure the success of the program. For example, local CHDP staff conduct ongoing training for eligibility workers to ensure that they are aware of the EPSDT program. To increase referrals, several county health departments also have established an EPSDT unit within the eligibility office. CHDP staff also do outreach in the community to broaden awareness of the program.

CHDP staff work very closely with the providers in their counties. They conduct provider recruitment and offer technical assistance to those participating in EPSDT. These efforts have been successful; 80 percent of the 3,500 EPSDT providers are in private practice.

In fiscal 1991 the CHDP program performed 2 million health screens on 1.4 million children, representing an increase of 22 percent from the previous year. About 800,000 of these children were Medicaid-eligible; 1.2 million of the health screens were paid for through EPSDT. The joint effort between Medicaid and the public health agency has resulted in a successful program.

Home Visiting in South Carolina

In the mid-1980s South Carolina conducted a review of its EPSDT program to assess its effectiveness. The study revealed that the program had low participation; less than 35,000 children were being served. More than 35 percent of those eligible declined to participate in the program. Even for children participating in the program problems were found. Adherence to the periodicity schedule was lacking. Provider participation also was a serious problem. A task force, composed of officials from several state agencies, including the Medicaid agency, the Health Department, and the Social Services Department, and the Governor's office, was convened to address these problems. Upon the task force's recommendation, the South Carolina Health and Human Services Finance Commission sent out a request for proposals asking organizations to develop and submit an outreach strategy for increasing both client and provider participation in the EPSDT program.

In 1985 a $1.5 million grant was awarded to the Department of Health and Environmental Control to carry out its plan to hire and train public health nurses. (Because the state was going to use skilled medical personnel, a 75 percent federal match was available. Thus, more than $1 million of the grant came from federal funds.) The department proposed that nurses located in local health departments work closely with their communities to aggressively outreach to both families and physicians in order to encourage their participation in EPSDT. Specifically, the nurses would conduct home visits to families with Medicaid-eligible children to inform them about the important preventive health benefit. In addition, health education and child assessments would be conducted during the nursing home visits.

The home visits are viewed as essential for two reasons:

- To follow up on initial declinations to the program. In many cases mothers do not fully understand and appreciate the importance of well-child care.
- To follow up on missed appointments. Missed appointments are reported by both providers and the local departments of social services, which make the initial appointments for clients. Home visits are made to assess why the appointment was missed and what can be done to ensure that a new appointment is made and kept.

Outreach nurses also visit new mothers in the hospital to solicit their interest and involvement in EPSDT for their newborns.

The success of the home visiting program is evident. In four years the number of EPSDT screens has doubled. South Carolina now performs 80,000 screens per year. The average one-year-old in the program used to receive one screen a year. That has now increased to an average of 2.7 screens in the first year of life. In addition, the decline rate has dropped from 35 percent to only 15 percent. The state also has been successful in increasing provider participation in the program. Because the outreach nurses spend so much time in their communities, the impact of the home visits has reached beyond EPSDT. These visits have resulted in referrals to important health services such as prenatal care, WIC, and family planning.

Public/Private Partnership in Pennsylvania

In Pennsylvania Medicaid is administered by the Department of Public Welfare. During the last twenty years this department's role has been evolving from a direct deliverer of service to a contractor of services. Ranking fiftieth in the nation for state employees as a percentage of state population, Pennsylvania's policy is to contract for services that can be provided cost effectively by the private sector. This has proven to be an appropriate approach for the management of the EPSDT program.

Automated Health Systems, Inc. (AHSI), a nonprofit firm located in Pittsburgh, was selected in 1987 through a competitive bidding process to run the EPSDT program. The firm is responsible for all phases of the program, including client outreach and education, appointment scheduling, transportation arrangement, provider identification, and followup for needed treatment. Additionally, AHSI is responsible for maintaining an adequate EPSDT provider network. This is accomplished by field representatives and medical evaluators who recruit, train, and encourage new EPSDT screening and treatment providers. Assistance also is provided to office staff to resolve billing and

other administrative problems. A hotline that gives information on client eligibility is available for EPSDT providers. Moreover, AHSI staff work closely with health and human service agencies across the state to ensure that appropriate referrals are made and that available services are coordinated for clients.

Operationally, the program is structured to ensure that AHSI staff have several contacts with clients. Initially, brochures with tear-off cards are provided to all families with eligible children during the welfare eligibility intake process. These cards are sent to the firm's central office in Pittsburgh, where they are entered into a computerized system and sorted by geographic area. Via telephone and letters, outreach staff contact the families in their area and schedule the screening appointment with the selected provider. To ensure that appointments are kept, reminder letters are sent to the families about a week before the appointment. A telephone call is made the day before the appointment.

AHSI also is responsible for other aspects of the EPSDT program. An integrated referral tracking system, which includes a county-by-county specialty resource file for identification of treatment sources, is one feature of the program. Outreach staff make referrals to specialty providers when problems are identified during screening examinations. The outreach staff also follow up with clients to ensure that they receive needed care. Although half of the children who require treatment and follow-up services get those services from their screening provider, the care of nearly 2,000 children per month is coordinated through the referral tracking system.

The success of the AHSI approach to EPSDT management is evident. Prior to 1987, when outreach and scheduling were handled by county social services staff, only 8,500 to 9,000 children per month received screening exams. Under AHSI this has doubled, with about 17,000 children being screened per month. Much of the company's success is attributable to the fact that former AFDC recipients, who tend to be more empathetic to current EPSDT clients, are hired as outreach staff. Moreover, children who need treatment services are virtually assured of their receipt through the automated referral tracking system.

AHSI has not only been effective in increasing client participation in EPSDT. Provider participation in the program also has doubled. Much of this success is attributable to an aggressive recruitment effort by field staff who help with billing and other administrative problems. These efforts have resulted in a 98 percent approval rate on provider claims. Clearly, the partnership between a private contractor and state government has resulted in an effective EPSDT program.

Conclusion

The management of EPSDT programs varies from state to state. Although a majority of states conduct the informing and scheduling of EPSDT within the welfare eligibility process, it is widely believed that this is not the most appropriate time to educate families on the preventive health benefit. Those states that contract this responsibility to other agencies express more satisfaction with the program's success. As states begin to develop strategies to enroll more children into EPSDT and to ensure their receipt of health screens, they also are looking to ensure that the management of the program includes a mechanism to link screens with treatment. These efforts are described in the next chapter.

7. Linking Treatment Services to Screening Services

Despite its name, which indicates that screening, diagnostic, and treatment services will be provided, EPSDT has always succeeded far better as a screening program than as a treatment program. State administrators have focused on the importance of informing families of the benefit. Providers have focused on the delivery of comprehensive health examinations. Federal reporting rules have focused on the number of children receiving screens. Yet little attention has been given to how the treatment portion of the program should be coordinated and administered. Program rules and regulations have provided only limited, broad guidance regarding what treatment services should be covered, who can provide them, and how an appropriate benefit package might be designed.

Recognizing this historical shortcoming, Congress took steps to resolve the problem through OBRA-89 by mandating that states cover treatment for any condition identified during a screen. Prior to this change, states were only required to provide any needed treatment service that was covered under the state Medicaid plan.

The NGA survey revealed that nineteen states believe their Medicaid benefit package is too extensive to feel any significant impact from this legislative change. However, a strong core of states indicated that the new EPSDT provision will be financially significant. The cost estimates ranged from $30 million in Illinois to $91.3 million in Florida. When asked to identify services for which they anticipate a greater demand as a result of the new provision, most states mentioned services consumed by two populations—the mentally ill and the developmentally disabled.

Ensuring that children get all the services needed to treat health problems presents many financial and systemic challenges for states. Coordinating their care in a cost-effective manner is critical. Much like what has been done successfully for pregnant women, states are beginning to think about how multiple state agencies can collaborate to develop a comprehensive delivery system for children. In particular, states are looking to combine the funds of their Medicaid agency and the knowledge of children's health needs within their Maternal and Child Health (MCH) program.

Opportunities for Collaboration

Historically, one mission of the MCH program is to provide health services to underserved children. Because Medicaid finances services for very low-income children there always has been some overlap in the populations each program serves. As discussed in the previous chapter, some state MCH agencies successfully perform EPSDT outreach activities. Additionally, MCH providers perform the screening examinations for many Medicaid-eligible children participating in EPSDT. Although state MCH agencies traditionally have identified children's health needs and provided

services either directly or through contracts, coordination of these activities with EPSDT has not been extensive in most states. In the wake of OBRA-89, there is a growing recognition that this type of collaboration is essential to ensuring that children get the services to which they are entitled.

MCH programs are in a unique position to help Medicaid programs fulfill the EPSDT requirements. Specifically, state MCH programs:

- Provide a single contact point that can help identify eligible children and encourage EPSDT participation;
- Offer a long history of providing care coordination/case management type activities that are critical to linking screening services to treatment services; and
- Have extensive experience in providing treatment services such as the therapies needed by children with chronic illness and disability.

Because of these functions MCH programs can assist Medicaid agencies in all phases of EPSDT, including outreach, case management, and the provision of new services that may not have been covered by Medicaid before OBRA-89.

In addition to the OBRA-89 requirements affecting EPSDT programs, the legislation included other key provisions that affect MCH programs and provide opportunities for states to successfully coordinate Medicaid and Maternal and Child Health activities. For example, assurances were added that require state MCH agencies to conduct outreach and provide assistance in enrolling Medicaid-eligible children.

States now face the challenge of formalizing the process of care coordination to ensure that all eligible children are enrolled, screened, and treated. Florida and New Mexico have seized the opportunities presented by the OBRA-89 legislation to build a comprehensive treatment program for children based on collaboration involving multiple state agencies. Their efforts are described below.

Florida's New Package of Treatment Services

Like many states, Florida's EPSDT program was viewed primarily as a screening program prior to OBRA-89. This component of the program was very successful with a 70 percent screening rate—one of the highest in the nation. Screens typically were conducted by county public health units, which subsequently referred one-third of the children for treatment. Many of these children had special health care needs and were treated through the state's Children's Medical Services program, but many of the services this program provided were not covered under Medicaid. Furthermore, no system existed to coordinate the two programs and the services they offered. With the passage of OBRA-89, the state began to explore what new services it would need to add to ensure that children have access to medically necessary services. The state also was concerned about developing a case management system to perform gatekeeping, referral, and tracking functions for children with special health care needs.

A key work group, composed of staff from Medicaid, MCH, and other divisions within the state's umbrella health agency, was formed to develop the case management system and to identify the services that had to be added to the state's Medicaid plan. The

following services were identified as necessary to ensuring the availability of comprehensive services and were added as part of the new EPSDT package of services:

- personal care
- skilled nursing care
- physical, speech, respiratory, and occupational therapies
- private duty nursing
- targeted case management services for alcohol, drug abuse, and mental health diagnoses

In addition to these services, the state expanded the durable medical equipment and organ transplant programs, eliminated hospital caps, and began reimbursing for immunizations provided by county public health units. Cost estimates put the package of new and expanded services at $70.5 million. It is being funded in part by a budget transfer from the Children's Medical Services (CMS) program. Initially, there was some mistrust among CMS administrators about the shift in funds. However, their support was forthcoming once it became apparent that through EPSDT many of the children on their waiting lists could be served.

The new program was phased in over a four-month period. Extensive statewide training was provided to all the divisions in the department that are involved with the new program, including Alcohol and Drug Abuse, Mental Health, Public Health, Medicaid, Children's Medical Services, Developmental Services, and Economic Services. A procedures guide covering all departmental programs has been developed that gives step-by-step directions on how a child enters the system, gets screened, and moves through care. The guide also includes information on billing procedures.

A service authorization process, based on medical necessity criteria that were developed with the state Maternal and Child Health agency and private providers, has been established. This process requires case managers from CMS, the county public health units, and Developmental Services to submit requests for high-cost services to nurses located at the eleven district offices in Florida. Specifically, prior authorization is required for the new therapies, private duty nursing, expanded prosthetics, expanded orthodontics, personal care, and entry into skilled nursing facilities.

Getting the new EPSDT benefit package operational has presented many challenges, several of which the state has met successfully in the short term. For example, getting all the relevant divisions to meet the challenge of implementing the OBRA-89 expansions was a significant achievement. Writing state plan amendments, developing provider manuals, creating reimbursement methodologies, and enrolling providers for all the new added services took a tremendous effort. Other challenges remain to fully implement the expanded program. Encouraged by these accomplishments, the state is optimistic about its chances for success.

New Mexico's Enhanced EPSDT Program

Unlike Florida, which expanded EPSDT as a direct result of the OBRA-89 legislation, New Mexico began exploring how its EPSDT program could be expanded prior to the

mandate. This effort primarily was in response to access problems experienced by children in need of mental health services. The problems were especially acute in the foster care system. Many foster care children needing such services could not obtain them because of a lack of Title XX funds and because such services were not covered by Medicaid. The state also had identified a problem centering around a lack of discharge alternatives for children in psychiatric hospitals. Many New Mexico children were being forced to stay in these institutions even when such care was not necessary or appropriate. To address these problems, the state began to explore how EPSDT could be expanded to meet the needs of children with mental health problems.

Working collaboratively, several divisions under the New Mexico Human Services Department began identifying the mental health services that needed to be added. With the passage of OBRA-89, the state broadened its approach to include services that were required for children who were medically at-risk. Specifically, the department named four critical populations for whom services were not available: severely emotionally disturbed, developmentally delayed, developmentally at risk, and medically at-risk children and adolescents. The agencies then developed a benefit package to meet the needs of these populations that included the following services:

- day treatment programs in psychiatric hospitals
- community mental health center services
- inpatient psychiatric services
- residential treatment center services
- social work services
- physical, speech, and occupational therapies
- private duty nursing
- therapeutic group home services
- psychosocial rehabilitation services
- specialized foster care services
- family education and training
- personal care services
- respite care services
- case management for medically at-risk children and adolescents

The agencies also developed a system for managing the receipt of these services. To be eligible for the enhanced Medicaid benefits, all conditions must be identified during an EPSDT screen. For those children who are identified as having a mental health condition, an individualized treatment plan must be developed and submitted to the Medicaid agency for prior approval. To ensure that services are family-centered the treatment plan must be developed in conjunction with the child (if appropriate), the parents or guardians, and other health care professionals, as appropriate. The individualized treatment plans are considered on a case-by-case basis.

Preliminary cost estimates put the enhanced EPSDT package at about $50 million by 1995. To minimize the budget impact and help ensure the program's success New Mexico, like Florida, will phase in implementation. The state also is working closely with Title XX providers to help them make the transition from grant-based funding to fee-for-service reimbursement. Once the program is fully operational, the state hopes to move more of the therapy services to schools where the children needing these services can easily access them. The state believes that the enhanced EPSDT benefits will go far in meeting the needs of New Mexico's children.

Conclusion

For many years EPSDT has been viewed primarily as a screening program. While OBRA-89 made significant changes to the "S" component of the program, it also included a major provision affecting the "D" and "T" components. By requiring the coverage of all services deemed medically necessary to ameliorate or lessen a physical or mental condition identified during a screen, states are having to focus significant energy in building a comprehensive package of benefits. In conjunction with these efforts many states also are looking at creating a system to improve the linkages between screening examinations and needed diagnostic and treatment services. Working collaboratively, multiple state agencies are meeting the challenges of OBRA-89 to build a coordinated, comprehensive health system for children through EPSDT.

III. Responding to the Needs of Substance-Abusing Pregnant Women and Their Infants

"The issue for us as governments, businesses, and social groups is how to get value and principles built around the concept of a meaningful future that is based on survival and life, not death and disease. How do we struggle with the 5 million women of childbearing age who are using drugs? The 1 million who are abusing cocaine? Last year, there were 345,000 children exposed to some drug or toxin in utero, and 100,000 who were exposed to crack cocaine alone. We must deal with these issues."

Reed V. Tuckson, M.D.
President
Charles R. Drew University of Medicine and Science
Formerly Senior Vice-President for Programs
March of Dimes Birth Defects Foundation

"Every month I sit down with the women participating in our residential drug treatment program and I ask them: What is it that you need? This program is designed by these women for these women. We need to be listening to the women so that programs and policies are designed to meet their needs."

Minnie Thomas
Director
Mandela House
Oakland, California

8. Understanding the Nature and Extent of Perinatal Substance Abuse

States continue to make huge advances in the area of prenatal care. However, they are realizing that there are still significant subpopulations of pregnant women that present special challenges. Specific initiatives are required to reach and treat pregnant women who are substance abusers. Policymakers are beginning to turn their attention to developing targeted programs to serve this subpopulation.

Before the development of programs can begin, states need to know the extent of the problem. Identifying women who are using drugs and alcohol while pregnant continues to be a major challenge. Frontline health care providers frequently do not recognize substance abuse in women, especially during pregnancy. Consequently, many pregnant substance abusers often are not diagnosed correctly, which hampers efforts to serve them. Several recent studies have tried to assess the prevalence of the problem and also to identify the barriers to correct diagnosis.

Extent of the Problem

The National Association of Perinatal Addiction Research and Education (NAPARE) has conducted several studies to determine the prevalence of drug and alcohol use among pregnant women. One study revealed an 11 percent prevalence rate. The study was limited in scope in several ways. Because information was taken from discharge data, it only identified women who used drugs immediately before delivery. The study did not include alcohol or tobacco. Also, because the majority of the thirty-six participating hospitals were large urban teaching hospitals, it only revealed the prevalence for one segment of the population. In response to these limitations, NAPARE conducted a broader study with two main objectives:

- To assess the extent of use of a variety of drugs such as alcohol, cocaine, marijuana, and opiates during pregnancy; and
- To assess whether women from different socioeconomic levels used drugs and alcohol at varying rates.

For six months in 1989, every pregnant woman in Florida's Pinellas County who received care from one of twelve private obstetrical practices participating in the study or from one of the five public health clinics was given a urine toxicology test at her first prenatal visit. Although the urine samples were "blind," some information on the women was collected to help identify socioeconomic characteristics.

The study revealed similarities between substance abusers in the public and private health care sectors. For example, there was very little difference in the prevalence rate and the types of drugs used among the two groups of women.

- Sixteen percent of the women receiving care through the public health sector (who were racially mixed and indigent) tested positive for drugs and/or alcohol, and 13 percent of the women receiving care through the private sector (the majority of whom were white and middle class) tested positive.
- Most frequently both populations used the same two drugs—cocaine and marijuana.
- White women had a slightly higher incidence of positive tests (15.4 percent) than did black women (14 percent).

Because Florida is one of eleven states that mandates reporting for child abuse and neglect when a newborn tests positive for substances after delivery, the study also was able to evaluate the reporting patterns of health care providers. By tracking the reports for six months in Pinellas County, NAPARE found that 10.7 percent of all black women were reported for child neglect and abuse because of perinatal substance abuse, but only 1 percent of the white women were reported. When compared with the number of black and white women delivering babies during this same period, the study revealed that the incidence of perinatal substance abuse among black women was reported ten times as often as it was for white women. When physicians were asked why this reporting discrepancy existed, two answers were given most frequently.

- They believed white women stopped substance abuse once they knew they were pregnant but black women did not.
- Black infants showed worse symptoms of drug exposure than did white infants.

Misconceptions about who abuses drugs and alcohol have led to frequent misdiagnoses of substance abuse during pregnancy. As policy is developed to address this problem, such misconceptions must be discarded.

Problems of Multi-Substance Abuse

Many studies have shown that most women who abuse drugs do not use only one substance. These women typically use many drugs and alcohol simultaneously. For example, the NAPARE study in Florida revealed that the women who tested positive for alcohol also tested positive for either marijuana or cocaine. Another NAPARE study focusing on the effects of cocaine during pregnancy found that 85 percent of the women used other drugs in addition to the cocaine. Such multi-substance use makes it difficult to isolate the effects of a single drug on fetal development and growth. However, recent studies are beginning to shed some light on these linkages.

Complications of Cocaine Use

Many studies have indicated a growing rate of cocaine use by women of childbearing age. New studies have focused on the effects of this drug on fetal development and growth. When cocaine is ingested, blood vessels constrict, the heart rate rapidly increases, and cardiac vasoconstriction occurs. When pregnant women use cocaine these vascular effects can cause serious complications for the fetus such as intrauterine strokes, intrauterine heart attacks, and spinal infractions.

One of the most serious complications of cocaine abuse during pregnancy is preterm labor due to uterine contractions brought on by the drug. Studies have shown that about 20 percent of babies born to cocaine-using women are of low birthweight. Consequently, mortality rates are higher for cocaine-exposed infants.

A ruptured placenta can be another result of cocaine use during pregnancy. Cocaine weakens placental vessels and tissues. Once in labor, a woman is at a much higher risk of rupture when the placental tissues tear away. In fact, women who use cocaine have a 3.7 times greater chance of abruption than those who do not.

Other problems result from the constriction of blood vessels. When this occurs, blood flow to the fetus is impeded. This may cause chronic intrauterine hypoxia and malnutrition. The constriction of the blood vessels also may cause problems of fetal disruption (i.e., the fetus may be developing normally, but when cocaine is introduced growth is disrupted). This can occur during any stage of pregnancy. For example, some infants exposed to cocaine during pregnancy have digit reduction deformities when the blood flow to the fingers and toes is impeded and their development is disrupted.

Although these physical problems are very serious, they only occur in about 20 to 30 percent of the exposed infants. Researchers also are beginning to uncover a larger problem, which is neurobehavioral damage to exposed babies. One study conducted by NAPARE focused on cocaine-exposed infants' ability to respond to their environment and tested their reflexes and responsiveness. The study found that these infants:

- Experienced significant difficulty in making eye contact;
- Experienced difficulty in reaching an alert responsiveness state in which normal feedback and bonding occurs; and
- Had difficulty in achieving a smooth transition from a calm, restful state to an alert, responsive state.

Despite these problems, however, a longitudinal study of these children is revealing that the factor having the greatest impact is not necessarily the drug exposure, but perhaps the environment in which they live. Furthermore, the study is showing that with the right interventions, the children can be mainstreamed into school and lead normal productive lives. Clearly, while drug exposure during pregnancy may cause serious complications for the newborns, these problems are not necessarily permanent.

Benefits of Treatment Services and Early Intervention

Exposed children are not the only ones who can benefit from appropriate interventions. Because cocaine can disrupt the growth and development of the fetus during any stage of pregnancy, stopping the drug use at any point may prevent some problems and lessen the severity of others. Of the 300 women participating in NAPARE's study, 40 percent became drug-free during pregnancy and those who continued to use them significantly reduced the amounts of drugs they took. Women in treatment experienced less severe birth outcomes than those who received no treatment services.

Although studies such as these are showing that women in treatment have better birth outcomes, only about 10 percent of the women in the United States needing treatment

receive it. Three major issues pose barriers that keep women from accessing drug treatment.

- **Personal Issues**. Many women deny their addiction or deny their pregnancy. A fear of punishment and shame contribute significantly to the reasons for denial.
- **Social Issues**. Living in an environment in which drug use is endemic and peer pressure to keep abusing drugs is significant can hamper a woman's ability to access treatment. Providers who feel poorly prepared to deal with substance abuse may be reluctant to serve these patients. Conversely, many treatment programs will not treat pregnant women.
- **Treatment Issues.** In many areas the cost of treatment programs is prohibitive. Further compounding this problem is the reduction of funds for many programs caused by local fiscal conditions. Even when treatment programs are available, however, the type of care delivered may not be appropriate for women. Most programs are still based on the classic twelve-step model that requires a long-term commitment and demands that the patient put other aspects of his or her life on "hold." While this approach may be effective for many men, it does not provide the specialized services that most women need such as follow-up treatment and child care.

Conclusion

Policymakers are beginning to understand the nature and extent of perinatal substance abuse. New studies are revealing that education is needed to recognize the signs of addiction and abuse, especially for health care providers serving pregnant women. New information on the effects of substance abuse on fetal development indicates that treatment at any time can have a positive impact. Policymakers are turning their attention to removing the barriers that many women face in accessing treatment.

9. Responding to the Maternal Substance Abuse Problem

Policymakers at all levels of government have identified substance-abusing pregnant women as a priority. These women have complex needs that will require the resources of multiple agencies. At both the state and federal levels, agencies are working together to develop a comprehensive response to the problem. Within the federal government, agencies such as the Alcohol, Drug Abuse, and Mental Health Administration, the Maternal and Child Health Bureau, and the Office for Substance Abuse Prevention have embarked on major initiatives to address this critical problem.

The efforts of these agencies are being coordinated by the Office of National Drug Control Policy, which has identified four major objectives on which to focus:

- Significantly increase the treatment capacity for pregnant substance abusers and their children. Special emphasis is being placed on identifying the specific barriers that are inhibiting state programs from expanding treatment services for this population.
- Develop and disseminate uniform guidelines and protocols on treatment approaches.
- Expand the ability to track changes in the availability of treatment services for pregnant substance abusers.
- Develop mechanisms for disseminating in a timely manner useful information coming from federal research and demonstration grants.

These objectives are being met by different agencies. Below are some examples.

The **Office of Treatment Improvement**, which is located within the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA), is developing guidelines for treatment programs serving pregnant and parenting women and their children. Designed for nonhospital-based residential and/or outpatient programs, the guidelines will encompass a broad range of services, including health, nutrition, housing, education, job skills, and parenting. The guidelines also will include formulas to help states determine the costs of such services for reimbursement purposes.

The **National Institute on Drug Abuse (NIDA)** has funded research grants to identify what services are most effective in encouraging addicted women, particularly those who are pregnant and parenting, to enter and remain in treatment. NIDA also is conducting a large prevalence study to obtain better national estimates on the number of pregnant women using substances.

The **Office for Human Development Services** has appropriated funds for demonstration projects that will provide services to children from substance-abusing

families. These funds will improve access to the appropriate interventions that many of the children need.

The **Health Care Financing Administration** has awarded demonstration projects to five states to develop innovative strategies for improving access to care for substance-abusing pregnant women. The projects also will evaluate the cost savings of these programs to Medicaid.

The **Office for Substance Abuse Prevention (OSAP)** and the **Maternal and Child Health Bureau (MCHB)** have jointly funded 138 demonstration projects that focus on community-level efforts to treat pregnant substance abusers by forging linkages between treatment programs, social services agencies, and prenatal health programs.

In response to the tremendous need for information OSAP, with assistance from MCHB, is also funding the Perinatal Substance Abuse Prevention Resource Center. The resource center has several different components, including a clearinghouse of findings from the most recent medical research in the field, training for professionals who serve pregnant substance abusers, and a policy center that will synthesize current legislative and policy information. It is expected that this resource center will fill a tremendous need for information by consolidating both policy-specific and research knowledge in the perinatal substance abuse field.

Clearly, these efforts demonstrate the high priority that the federal government has placed on responding to the needs of this special population. By working collaboratively to fund demonstration and research projects to serve pregnant substance abusers, while focusing on developing mechanisms to share information, the federal government is helping states meet the needs of substance-abusing pregnant women.

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July 22, 1992

MEMORANDUM

TO: Interested Parties

FROM: Janine Breyel

RE: Release of New Maternal and Child Health Publication from the Health Policy Studies Division of the National Governors' Association

I am pleased to send you a copy of Gaining Ground: State Initiatives for Pregnant Women and Children. Based on the National Governors' Association's conference held last May in San Francisco, it contains valuable and exciting information on state efforts to improve the health status of mothers and children.

This report is the ninth in a series developed under the project, "Facilitating Improvement of State Programs for Pregnant Women and Children." It is supported through a cooperative agreement with the Maternal and Child Health Bureau of the U.S. Public Health Service. Gaining Ground: State Initiatives for Pregnant Women and Children summarizes information presented at the conference, including findings from recent evaluations of prenatal care reforms, approaches for improving children's health, and strategies for meeting the special needs of women who use alcohol and other drugs while pregnant.

As was apparent at the conference, states have made impressive progress but are still facing many challenges as they try to address the complex needs of these critical populations. It is hoped that this report captures the exciting dialogue that took place in San Francisco detailing this progress as well as the work remaining.

If you have any questions or would like further information please call me at (202) 624-5851.

10. Financing Substance Abuse Treatment Services

Although there is much activity at the federal level to address the problem of substance-abusing pregnant women, states are faced with the challenge of building a statewide treatment capacity that incorporates a stable funding base. Federally funded research and demonstration projects are short-lived and usually concentrated in one geographic area. With a renewed emphasis on approaching the problem of substance abuse during pregnancy as a health crisis, many states have turned toward Medicaid as a funding source because of its historic role in reimbursing for health services provided to low-income populations. Also, because of its entitlement nature it ensures that all eligible women can receive covered services.

Historically, reimbursement for treatment services under Medicaid has been biased toward hospital-based detoxification. Primarily, this is a result of coverage of hospital services being mandated by federal statute. While clearly needed in some cases, however, detoxification is costly and often does not ensure continuity of care. States may end up paying to have the same patients detoxed over and over again because no mechanism exists to link patients with ongoing substance abuse treatment once detoxification is complete.

Covering Outpatient Treatment Services

Other categories of Medicaid-covered services can be used to pay for substance abuse treatment. The most flexible categories allow for the reimbursement of outpatient treatment services, including:

- prescription drugs to pay for methadone maintenance
- rehabilitative services
- clinic services
- outpatient hospital services
- targeted case management

Using these service categories, states can develop a broad range of treatment programs that incorporate many services such as assessment and counseling.

States also have the option of developing residential treatment programs that are not hospital-based. However, there is relatively little flexibility for Medicaid coverage of services provided in these types of programs. While it is widely recognized that many patients must be removed from high-risk environments to ensure effective treatment, efforts to develop comprehensive treatment programs that include a residential com-

ponent have been thwarted by a Medicaid regulation known as the "IMD exclusion." This regulation is described below.

Exploring the Special Problem of the IMD Exclusion

When the Medicaid statute was enacted in 1965 it included a provision prohibiting states from paying for the care of persons housed in institutions for mental disease (IMDs). Section 1905 (i) of the Social Security Act defines IMDs as facilities with more than sixteen beds "providing diagnosis, treatment, or care of persons with mental diseases" above age twenty-one and below age sixty-five. Because a substance abuse diagnosis is included in the definition of a mental disorder, HCFA has determined that IMDs include free-standing residential alcohol and drug abuse treatment programs. Because an individual residing in an IMD loses Medicaid eligibility, this exclusion is even more critical for pregnant women. A pregnant woman in a residential treatment facility would not have Medicaid coverage for prenatal care services or any other health services she may need.

Given these constraints, several options exist for states to develop residential programs that include, at least in part, Medicaid-covered services. However, all these options have significant limitations. They include the following:

- Develop residential programs that have sixteen beds or less. In such programs, Medicaid will only pay for the costs of treatment services and not the costs associated with room and board.
- Help facilities that serve women below twenty-one years of age become accredited by the Joint Commission on Accreditation of Health Care Organizations under its *Consolidated Standards Manual.* HCFA has determined that a facility having such accreditation meets the Medicaid definition of "phychiatric facility," even though the facility is not licensed by the state as such.
- Develop facilities that operate as units of an acute care hospital. This arrangement can be very costly since the care is reimbursed under the hospital rate.
- Develop programs that provide treatment off site. Since the residential component would not be "providing diagnosis, treatment, or care," it should not be considered an IMD. Treatment would be covered as an outpatient service. However, a separate funding source would be needed to pay the residential costs of the patients since room and board would not be reimbursable under Medicaid.

Conclusion

By looking carefully at the various Medicaid service categories, many options exist to fund treatment services both on an inpatient and outpatient basis. It may not be easy, yet in many states where raising new revenue for substance abuse treatment services is not

politically feasible, turning toward existing funding sources may represent the only option for paying for treatment programs. The efforts of three states that have collaborated with various agencies to help fund these critical services are described in the next chapter.

11. Developing State Programs to Serve Substance-Abusing Pregnant Women

Although states have made impressive progress in reforming state programs for pregnant women, many of their efforts have been stymied by the special problems that substance-abusing pregnant women present. Women in this subpopulation have needs that encompass a broad range of services. States are now beginning to turn their attention to meeting those needs by pooling the resources of multiple agencies that serve these women and their families.

The need for such efforts is clear. In a 1989 study by the National Association of State Alcohol and Drug Abuse Directors (NASADAD) states estimated that 250,000 pregnant women across the country were in need of substance abuse treatment. Yet only 29,000 women were actually in treatment and receiving services. In 1991 the National Governors' Association embarked on a study to assess the level of activity in which the states were engaged to address this critical problem. A preliminary survey was administered to five different state agencies.

- Alcohol and Drug Abuse agencies were contacted to determine what policies were in place, what programs were available to treat this special population, and how treatment services were coordinated with other services that women need.
- Maternal and Child Health agencies were queried about how they were coordinating their efforts to provide health services with other agencies' efforts to provide substance abuse treatment services.
- Medicaid agencies were asked about the extent to which they reimbursed for treatment services and about their involvement in developing programs to serve this population.
- Children with Special Health Care Needs programs that are experiencing an influx of exposed infants who need their services were surveyed to examine the degree to which they were collaborating with other agencies to address the problem.
- Finally, Child Welfare agencies that are identifying the families in need were queried to assess their involvement with collaborative efforts to ensure that these women receive needed services.

The results of these initial surveys demonstrated that states do consider this population a priority and are beginning to focus on addressing their needs. An overwhelming majority of states (75 percent) said that a special task force or work group has been established to examine the problem and to develop strategies to most appropriately serve these women. Most of these work groups involve multiple state

agencies and are focusing on collaborative efforts to address the problem. Other survey results are encouraging. For example, thirty states reported that their Alcohol and Drug Abuse agencies have developed specialized treatment programs to serve pregnant substance abusers. Twenty-three state Maternal and Child Health agencies responded that they have developed programs to treat this special population.

Clearly, states are beginning to struggle with developing programs that will meet the complex needs of substance-abusing pregnant women. NGA identified a number of states that have developed innovative and collaborative programs to serve pregnant women with substance abuse problems. Washington, Oregon, and California are three of these states. Their programs are described below.

Washington's Multifaceted Approach

In 1989 Washington declared substance abuse a public health issue that required an appropriate public health response. That same year the state legislature passed sweeping legislation that provided the policy and financial framework for the state to begin developing a comprehensive program to treat individuals with substance abuse problems. While not specifically targeted to pregnant women, the legislation did contain key provisions that identified this population as a priority. Significant reforms to the state's perinatal programs also were made the same year. With these important changes, the state began aggressively developing a coordinated system to respond to the substance abuse needs of pregnant and parenting women.

Washington's Omnibus Drug Act of 1989, which was identified by the American Bar Association as the strongest piece of legislation in support of treatment for substance abusers, contained many important provisions. For example:

- $5.5 million was appropriated for treatment services for low-income, chemically dependent, pregnant and postpartum women. Specific services required by the act include inpatient treatment, an ambulatory treatment facility for HIV-positive/AIDS patients, outpatient treatment services, and housing.
- $12.2 million was appropriated for youth assessment and treatment programs, including both inpatient and outpatient services.
- $3 million was appropriated for communities to develop collaborative projects between prevention, treatment, education, and enforcement activities.

Concurrently, the state passed other legislation that improved services for this critical population. These changes included:

- The Alcoholism and Drug Addiction Treatment and Support Act (ADATSA) was revised to designate low-income, chemically dependent pregnant women and parents with small children as priority populations for treatment.
- The Maternity Care Access Act (implemented as the First Steps program) expanded Medicaid coverage for pregnant women to 185 percent of poverty and added critical support services to the Medicaid-covered benefits, including psychosocial assessment, nutritional services, health education, transportation, and case management.

The following year efforts to treat pregnant women were enhanced further. Medicaid began covering medical stabilization and detoxification for pregnant women and adolescents. Moreover, funds were appropriated for child care services to ensure that women were not inhibited from accessing treatment because of this barrier.

With these important pieces in place, the state's umbrella agency, the Department of Social and Health Services, formed an interagency group to develop a strategy for implementing an effective continuum of care for pregnant and parenting substance-abusing women. The members of this group included representatives from Income Assistance, Medicaid, Maternal and Child Health, Substance Abuse, Child Protective Services, and the Office of Research Data Analysis. The first step for this group was to review the policies of each agency to find areas of conflict. For example, the policy of Child Protective Services was to remove children from the home if the mother was abusing drugs. However, the overarching goal of the new program was not punitive but rather to help the mother access treatment and keep the family together. Working together, the group addressed such conflicting policies and developed a treatment protocol that provides for a coordinated system of care for substance-abusing women and their families.

The Treatment Protocol for Chemical-Using Women is a step-by-step approach to serving women with substance abuse problems. The continuum of care that involves various providers includes the following services:

- prenatal care
- case management
- transitional housing
- child care
- assessment
- hospital-based medical stabilization
- residential treatment
- intensive and regular outpatient treatment

The new program emphasizes the Medicaid-covered targeted case management for chemical-using pregnant women as the critical service that ensures women have access to needed services and links the continuum together.

Once the continuum of care was developed, the interagency group then began focusing efforts on capacity building at the local level. Training was conducted in welfare offices to ensure the responsiveness of eligibility workers to the needs of the women. Substance abuse counselors who were not comfortable treating women, especially pregnant women, were offered training on the new approach and the treatment protocol. In addition, the interagency group worked with the legal community to inform members of the availability of the new program as an alternative to prosecution.

The success of the program is apparent. In 1982 only 17 percent of the individuals in the alcohol and drug abuse system were female and virtually none were pregnant. Currently, 33 percent are women and of those 10 percent are pregnant when

they enter the system. The state attributes much of its success to the involvement of counties and communities as the program was developed. Multi-level groups representing employees at both the local and the state levels developed the protocol.

Despite the program's success, challenges remain. For example, child care regulations dictating certain safety standards may keep many residential programs from providing this necessary service. In addition, obstetrical provider participation problems remain a barrier for many women accessing prenatal care services, especially those with substance abuse problems. Data from the Office of Research Data Analysis shows that women are not seeking treatment early in their pregnancies. Thus, the state is focusing on identifying women early and referring them to treatment. As a result of recent outreach efforts, 60 percent of all pregnant/postpartum admissions for treatment over the last six months were in the first or second trimester. The state believes that the critical pieces are in place to effectively provide a continuum of care for pregnant and parenting substance-abusing women.

Oregon's Integrated Funding Approach

In 1985 Oregon's legislature authorized a major reorganization of the state's health and social services agencies. One change was to move the Alcohol and Drug Abuse program out of the Mental Health agency. Recognizing that clients with substance abuse problems in other agencies of the Department of Human Resources (DHR) would not benefit from many of the other social services provided to them until their addiction problems were addressed, the Alcohol and Drug Abuse program was elevated to an agency within the Director's Office of the department. In this way, the agency gained an important policy perspective. Concurrently, the Medicaid agency was moved into the same office, and Medicaid specialists were assigned to each of the agencies within DHR to identify state-funded services that could be covered by Medicaid. These changes were important as the state began to aggressively address the problem of substance-abusing pregnant women.

In 1989 a task force was established to examine the problem of alcohol- and drug-abusing women. The task force found that although 30 percent of the individuals in the alcohol and drug abuse system were female, there were very few treatment programs tailored for women. Furthermore, few of the support services needed by women, especially those who were pregnant and parenting, were available.

The task force's report resulted in the establishment of certain contract requirements for designated women's slots in programs funded by the Alcohol and Drug Abuse agency. There are six mandated components for the treatment of women, including appropriate assessments to identify special needs, the development of a care plan to ensure the provision of needed services, the availability of qualified staff, the availability of self-help groups for women, and the development of after-care plans.

A substantial increase in the ADAMHA block grant as well as the earmarking of tax revenue from the sale of beer and wine created opportunities for the state to begin aggressively pursuing treatment options for women. More than half of the increase in the block grant funds was designated specifically for pregnant women. With these funds, the state was able to add eighty residential beds and 100 intensive outpatient slots

to the continuum of services, and to fund several local demonstration after-care projects.

As the Alcohol and Drug Abuse agency has added treatment capacity for women, it has aggressively pursued Medicaid reimbursement of outpatient services through the rehabilitation option. Oregon has found this category of service to be more flexible than the clinic option. For example, services can be delivered in multiple settings including the home. Also, providers are able to bill for telephone consultations. Under the rehabilitation option, Medicaid only reimburses those treatment providers deemed "comprehensive." Primarily, these are county mental health agencies that deliver, either directly or through subcontracts, a continuum of care. Quality assurance is maintained through the use of comprehensive providers and an aggressive site review process and Medicaid audit program.

The number of residential programs for pregnant women also is growing, though the IMD exclusion continues to be a problem. One strategy the state is using to obtain Medicaid reimbursement is to transport women from the residential facilities elsewhere to receive treatment services. While the state is not satisfied with this approach, for the moment it is a viable option.

The Alcohol and Drug Abuse agency also has been successful in getting additional revenue from other agencies into the Office of Alcohol and Drug Abuse Programs. For example, the welfare agency committed $500,000 to provide the state's Medicaid match for treatment services as a component of the welfare reform strategy. To fund child care services for addicted women in treatment, $750,000 of the child care block grant has been designated. Additionally, the Children's Services Program transferred $800,000 of its funds into the Alcohol and Drug Abuse Programs' budget to help serve its clients, most of whom are Medicaid-eligible.

Oregon's efforts to treat pregnant women were further enhanced by the finding of a 1990 task force appointed by the Governor to explore legal options for addressing the problem of substance-abusing pregnant women. Members of the task force decided unanimously that it was inappropriate to commit these women to the legal justice system when there was not enough treatment capacity available to serve those who voluntarily wanted services.

The state has made a strong commitment to funding alcohol and drug abuse treatment services, particularly for women. In the last two years the proportion of women receiving treatment services has grown from 30 percent to 37 percent. Much of this has been possible due to the state's willingness and determination to obtain Medicaid reimbursement for many needed services. In 1985, 2 percent of the Medicaid budget was directed toward the funding of alcohol and drug treatment services. By 1991, this had grown to about 11 percent. This commitment continues. The state also is looking at increasing Medicaid reimbursement for treating children and adolescents through the Early and Periodic Screening, Diagnostic, and Treatment Program.

California's Coordinated Approach

In 1988 an interagency task force was established in California to respond to two disturbing trends. First, there was a tremendous increase in the number of drug-exposed

infants being referred to the state's regional centers for developmental assessments and services. Second, there was a large increase in the number of substance-exposed children placed in foster care. The Health and Welfare secretary brought together representatives from the Departments of Social Services, Health Services, Developmental Services, and Alcohol and Drug Programs to assess the extent of perinatal substance abuse, to identify what services were available to treat this population, and to identify what new services were needed to effectively serve substance-abusing women.

The group identified a number of issues that were contributing to the growing number of substance-exposed infants. Many pregnant women with substance abuse problems received little or no prenatal care. Pregnant and parenting substance-abusing women and their children had a range of social and housing problems with which they needed assistance. Moreover, very few alcohol and drug treatment programs existed for pregnant and parenting women and the few programs available had very long waiting lists.

To address these barriers, the state interagency task force designed the Options for Recovery program. Piloted in five large communities, the program's goal is to provide early intervention services to prevent the potentially devastating effects of maternal substance abuse on infants. In 1990 Options for Recovery was codified into law, and the legislature established the Office of Perinatal Substance Abuse in the Department of Alcohol and Drug Programs. This office was designated as the lead office responsible for monitoring the pilot sites and responding to inquiries about the program from the public and the legislature.

The structure of the Options for Recovery project is designed to promote a high level of collaboration between agencies involved at both the state and local levels. Each project was required to establish a Perinatal Substance Abuse Coordinating Council (PSACC) and to identify a local lead agency to work with the state interagency task force. In some of the pilot sites the local health department has been designated as the lead agency. In other sites it is the local alcohol and drug office. The requirement to establish a PSACC often brought together, for the first time, providers in the county serving these populations. The PSACC is responsible for ensuring that the pilot programs provide the following services:

- case management
- alcohol and drug treatment
- specialized foster care that incorporates recruitment and training and respite care
- community-based client outreach

Through the state's Comprehensive Perinatal Services Program, women participating in Options for Recovery also are able to access enriched prenatal care services, including nutritional assessment, health education, psychosocial intervention, and high-risk medical management.

Funding to create the pilots came from the Maternal and Child Health and the Alcohol, Drug, and Mental Health block grants and from state general revenue. Medicaid reimburses for methadone maintenance, detoxification services, and out-

patient services including intensive day treatment. Medicaid also covers the enriched prenatal care services that are provided to these women. The Options for Recovery program is expanding to two new sites at a cost of $4.5 million. This will bring the total annual budget of this program to $12.5 million.

A major component of the pilot projects is an evaluation of their effectiveness. The Department of Alcohol and Drug Programs is responsible for coordinating this effort, which involves not only an examination of the gathered data to test the model's effectiveness, but also an examination of the coordination and collaboration of the agencies involved in the program. Although it is too soon to determine the pilots' effectiveness, early indications are quite encouraging. San Diego County recently reported that forty-three of forty-nine babies born to women in the pilot project tested substance-free at birth.

The state is encouraged by the initial success of the new program. Although many obstacles remain to ensure that women have access to the perinatal health and substance abuse treatment services they need, a recent gubernatorial initiative reflects the state's ongoing commitment to this population. The Governor has proposed a $25 million perinatal substance abuse initiative that will be paid for in part from increased taxes on alcohol. Through these efforts the state hopes to continue to address the needs of pregnant and parenting substance-abusing women.

Conclusion

Meeting the needs of substance-abusing pregnant and parenting women presents many challenges for states. Developing programs that incorporate specialized alcohol and drug abuse treatment services with important health care services requires the commitment of multiple state agencies. Many states have begun to respond to this challenge and are developing policies and programs that involve the resources and expertise of Alcohol and Drug Abuse, Maternal and Child Health, Medicaid, and Child Welfare agencies.

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Appendix: Conference Agenda

EVALUATING THE IMPACT OF PERINATAL REFORMS

WEDNESDAY, MAY 1

9:00 a.m.-9:15 a.m.	**Welcoming Remarks** John Luehrs, *Director, Health Programs, National Governors' Association* David Heppel, *Director, Division of Maternal, Infant, Child, and Adolescent Health, Maternal and Child Health Bureau, Health Resources and Services Administration*
9:15 a.m.-9:30 a.m.	**Overview of National Governors' Association/Maternal and Child Health Bureau Project** Ann Koontz, *Chief, Maternal and Infant Health Branch, Maternal and Child Health Bureau, Health Resources and Services Administration* Ian Hill, *Senior Policy Analyst, National Governors' Association*
9:30 a.m.-10:15 a.m.	**Collaborating at the Federal Level** Robert Harmon, *Administrator, Health Resources and Services Administration* Christine Nye, *Director, Medicaid Bureau, Health Care Financing Administration*
10:15 a.m.-10:45 a.m.	**Break**
10:45 a.m.-noon	**Have Eligibility Expansions Translated into Enrollment?** Jeffrey P. Mayer, *Project Manager, U.S. General Accounting Office* Linnea Taylor, *Program Consultant, Vermont Medicaid* Susan Tucker, *Chief, Division of Maternal and Child Health, Maryland Medicaid* *Moderator*: Ian Hill, *National Governors' Association*
Noon-1:30 p.m.	**Lunch** **Promoting Maternal and Child Health in the Private Sector** Liz Cronin, *Manager of Health and Welfare Plans, Levi Strauss & Co.*

1:30 p.m.-2:45 p.m.	**How Can We Measure Access and Provider Participation?** Deborah Lewis-Idema, *Vice President, MDS Associates* Fred Connell, *Associate Professor, Department of Health Services, University of Washington* *Moderator*: L. Carl Volpe, *National Governors' Association*
2:45 p.m.-3:15 p.m.	**Break**
3:15 p.m.-4:45 p.m.	**Have Prenatal Care Reforms Made A Difference?** Carolyn Goforth, *Chief of Preventive Services, North Carolina Medicaid* Peter van Dyck, *Director, Utah Family Health* Tricia Leddy, *Chief, Office of Primary Care, Rhode Island Maternal and Child Health* *Moderator*: Athole Lennie, *Health Program Specialist, California Maternal and Child Health*
4:45 p.m.-5:30 p.m.	**The Challenge of Perinatal Evaluation** Milton Kotelchuck, *Chairman, Department of Maternal and Child Health, University of North Carolina at Chapel Hill*

IMPROVING CHILDREN'S HEALTH CARE PROGRAMS

THURSDAY, MAY 2

9:00 a.m.-10:00 a.m.	**Designing a Model Child Health System** Morris Green, *Perry W. Lesh Professor of Pediatrics, Indiana University School of Medicine* *Moderator*: David Heppel, *Director, Division of Maternal, Infant, Child, and Adolescent Health, Maternal and Child Health Bureau, Health Resources and Services Administration*
10:00 a.m.-10:30 a.m.	**Break**
10:30 a.m.-11:45 a.m.	**Increasing Pediatricians' Participation in Medicaid** Barbara Frankel, *Director, Maternal and Child Health Unit, New York Medicaid* Janet Olszewski, *Acting Chief, Children's Special Health Care Services, Michigan Maternal and Child Health* *Moderator*: Janine Breyel, *National Governors' Association*
11:45 a.m.-1:15 p.m.	**Lunch** **The Congressional Agenda for Children** Marina Weiss, *Chief, Health, Income Security, Social Services Section, Senate Finance Committee*
1:15 p.m.-3:00 p.m.	**Ensuring That All Children Receive Preventive Screens** Ian Hill, *Senior Policy Analyst, National Governors' Association* Gordon Cumming, *Chief, Child Health and Disability Prevention, California Family Health* Ann Lee, *Director, Division of Children's Health, South Carolina Maternal and Child Health* Gerald Radke, *Director, Pennsylvania Medicaid* Bob Doran, *President, Automated Health Systems, Inc.* *Moderator*: Bill Hiscock, *Chief, Program Initiatives, Medicaid Bureau, Health Care Financing Administration*
3:00 p.m.-3:30 p.m.	**Break**

3:30 p.m.-5:15 p.m.	**Linking Treatment Services to Screening Services** Richard Nelson, *Director, Child Health Specialty Clinics, Iowa Maternal and Child Health* LuMarie Polivka-West, *Director, Licensure and Certification, Florida Medicaid* Kathleen Valdes, *Supervisor, Program Development, New Mexico Medicaid* Moderator: Ian Hill, *National Governors' Association*

MEETING THE NEEDS OF ALCOHOL- AND DRUG-ABUSING PREGNANT WOMEN AND THEIR CHILDREN

FRIDAY, MAY 3

9:00 a.m.-10:00 a.m.	**Understanding the Nature and Extent of the Problem** Ira Chasnoff, *President, National Association for Perinatal Addiction Research and Education*
10:00 a.m.-10:30 a.m.	**Break**
10:30 a.m.-11:15 a.m.	**Financing Care: Challenges and Responses** David Gates, *Staff Attorney, National Health Law Program* *Moderator*: Ellen Hutchins, *Social Work Consultant, Maternal and Child Health Bureau, Health Resources and Services Administration*
11:15 a.m.-noon	**Making a Treatment Program Work** Minnie Thomas, *Director, Mandela House, Oakland, California* *Moderator*: Ellen Hutchins, *Social Work Consultant, Maternal and Child Health Bureau, Health Resources and Services Administration*
Noon-1:30 p.m.	**Lunch** **Building Partnerships for Prevention** Reed Tuckson, *Senior Vice President for Programs, March of Dimes*
1:30 p.m.-3:00 p.m.	**Coordinating the State Effort** Janine Breyel, *Senior Research Assistant, National Governors' Association* Maxine Hayes, *Director, Washington Parent and Child Health* Kenneth Stark, *Director, Washington Alcohol and Substance Abuse* Bob Labbe, *Program Coordinator, Oregon Medicaid* Jeffrey Kushner, *Director, Oregon Alcohol and Drug Abuse* Terence Smith, *Medical Consultant, California Maternal and Child Health* Sherry Conrad, *Director, California Alcohol and Drug* *Moderator*: Diane Canova, *Director of Public Policy, National Association of State Alcohol and Drug Abuse Directors*

RELATED PUBLICATIONS AVAILABLE FROM NGA

Gaining Ground: State Initiatives for Pregnant Women and Children, edited by Janine Breyel, is one of a series of publications on state perinatal and child health program issues published by the Health Policy Studies unit within NGA's Center for Policy Research. May 1992. $15.00. No. 18562. Other recent publications addressing state perinatal program issues include:

Reaching Women Who Need Prenatal Care: Strategies for Improving State Perinatal Programs, by Ian T. Hill. June 1988. $15.00. No. 18002.

Since early 1987, a majority of states have implemented expanded Medicaid programs for pregnant women and young children living in poverty. To improve these populations' access to early and appropriate prenatal care, numerous states are also streamlining their systems for eligibility and outreach. Extensive discussion of presumptive eligibility is included.

Estimating Medicaid Eligible Pregnant Women and Children Living Below 185 Percent of Poverty: Strategies for Improving State Perinatal Programs, by Paul W. Newacheck. June 1988. $15.00. No. 18004.

This volume estimates potential Medicaid eligibles with incomes below 185 percent of poverty.

Increasing Provider Participation: Strategies for Improving State Perinatal Programs, by Deborah Lewis-Idema. July 1988. $15.00. No. 18003.

Assuring adequate provider participation has been a perennial concern for Medicaid and Maternal and Child Health programs. This document describes the scope of the problem and provides insights into states strategies to expand obstetrical provider participation.

Coordinating Prenatal Care: Strategies for Improving State Perinatal Programs, by Ian T. Hill and Janine Breyel. July 1989. $15.00. No. 18036.

To complement state efforts to expand Medicaid eligibility for low-income pregnant women and children, states are also beginning to initiate reforms in their service delivery systems. In an effort to improve access and continuity of care, states have implemented programs of prenatal care coordination or case management. This report details the component parts and early experiences of these systems.

Enhancing the Scope of Prenatal Services: Strategies for Improving State Perinatal Programs, by Trude Bennett and Ian T. Hill. March 1990. $15.00. No. 18037.

To improve the health status of mothers and children, states have significantly expanded the types of prenatal care services provided under Medicaid, adding "support" services such as care coordination, nutritional counseling, psychosocial counseling, and health education.

Designing Program Evaluations: Strategies for Improving State Perinatal Programs, by Linda T. Bilheimer. July 1989. $15.00. No. 18038.

Measuring the impact of efforts to improve maternal and child health remains a critical challenge to all states implementing perinatal initiatives. This report discusses a broad range of evaluation approaches.

Improving State Programs for Women and Children: Conference Proceedings, edited by Janine Breyel. April 1990. $15.00. No. 18060.

On the two-year anniversary of the enactment of OBRA-86, 300 individuals convened in San Antonio, Texas, to assess state progress in improving maternal and child health. This report summarizes the conferees' discussion.

Caring for Kids: Strategies for Improving State Child Health Programs, by Ian T. Hill and Janine M. Breyel. April 1991. $15.00. No. 18500.

States are beginning to focus significant energy and resources on improving child health programs. This report presents detailed information on state responses to recent legislation that dramatically expanded Medicaid coverage and made sweeping changes to the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program for children. It also offers insights on how states can achieve further progress in improving the accessibility and effectiveness of their health care programs for children.

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